HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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2008 Legislative Session

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.03 - RULES GOVERNING CHILD SUPPORT SERVICES

DOCKET NO. 16-0303-0801

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is December 6, 2007.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Sections 32-1214G and 56-203A, Idaho Code, and mandated by the Federal Deficit Reduction Act (DRA) of 2005.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

This rule implements a federal mandate from the Deficit Reduction Act (DRA) of 2005. Each State is required to set up a process to collect a $25 annual fee for each enforced child support case that has never participated in a cash assistance program. Collection of this annual fee is to take place once $500 in support payments has been collected on each case, each year. For every $25 collected, the federal government receives $16.50 and states receive $8.50. Idaho is planning to use the $8.50 collections to help cover the federal share of the fee on cases in arrears where collection of the fee cannot be applied. Idaho must implement this program or face loss of federal TANF funds.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)a and b, Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Failure to comply with the DRA mandate would violate state plan requirements, which would expose the state to penalties or potential loss of Idaho's TANF funding. The loss of this funding would create an immediate danger to the health and safety of children and families in Idaho.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein:

This rulemaking imposes a new $25.00 dollar annual fee upon the non-custodial parent paying "enforced" child support payments. The Federal Budget Deficit Reduction Act of 2005 mandates that this fee be imposed in each child support case in which an individual has never received assistance under a program funded by the Temporary Assistance for Needy Families (TANF) program (Title IV-A of the Social Security Act) and where the state has collected more than $500 in child support during the Federal Fiscal Year (FFY). Despite the fact that the Federal law requiring this fee was passed during the 2005 Federal Legislative Session, the proposed Federal Regulation governing the application and imposition of this fee was not published until January 24, 2007.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

The projected fiscal impact for SFY 2009 is $399,674 general fund dollars, which will be required in order to advance the payment of the federal share of the fee on cases which qualify for the fee but on which collections cannot be applied to the fee due to existing case arrearages and inability to collect. (Not included in this fiscal impact statement is the total cost to the Department for system modification of $192,960. Of this total, $86,746 is the Child Support Program's responsibility.)

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Kandace Yearsley at (208) 334-0620.

DATED this 12th day of December, 2007.

Sherri Kovach, Program Supervisor
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450 West State Street - 10th Floor
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(208) 334-5564 phone; (208) 334-6558 fax
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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

304. FEES.

01. Application Fee. At the time of application for child support services, a written application must be completed and a fee of twenty-five dollars ($25) must be paid. The fee must be paid in advance of any services to be provided and is not refundable. (7-1-98)

02. Income Tax Offset Fees. A fee of twenty-five dollars ($25) will be deducted each time child support is collected as a result of an income tax offset. (7-1-98)

03. Internal Revenue Service (IRS) Referral Fees. A fee of one hundred twenty-two dollars and fifty cents ($122.50) shall be charged for a referral to the IRS for full collection of the child support obligation. (7-1-98)

04. Locate Fees. Child Support Services may charge an applicant/recipient a fee of ten dollars ($10) for referral to FPLS for location of a non-custodial parent when no other child support services are being provided. Child Support Services may also charge a fee of four dollars ($4) for referral to the FPLS for a social security number search. Child Support Services may charge a fee of seventy cents ($.70) for referral to FPLS for location of a non-custodial parent. (7-1-98)

05. Federally Mandated Annual Service Fees. Child Support Services must charge

an annual fee of twenty-five dollars ($25) for each Title IV-D enforcement case in which Child Support Services has collected and disbursed five hundred dollars ($500) of support in the federal fiscal year. The fee will be billed to the child support obligor once five hundred dollars ($500) of support has been collected during the relevant federal fiscal year provided the case otherwise qualifies. The fee will not be collected on any case in which the applicant/recipient has ever received benefits under a State or Tribal Title IV-A program, or from any child support obligor who is currently required to participate in Title IV-D services as an eligibility requirement for Food Stamps participation. (12-6-07)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0707

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 1, 2007.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also Title XIX and Title XXI of the Social Security Act, as amended, and the companion federal regulations.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than Wednesday, November 21, 2007.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

As part of the Department's Medicaid Modernization project, a selective contract has been awarded to Blue Cross of Idaho to provide dental insurance coverage for Medicaid Basic Plan participants. This means the contractor will be providing the dental insurance program instead of Medicaid covering dental services directly.

Currently, the Basic Plan benefits rules list all the Medicaid-covered dental services, including the procedure codes. This rulemaking removes reference to the Medicaid-covered dental services since the insurance contractor will be providing dental insurance coverage for these services under their contract beginning September 1, 2007. The companion rulemaking for these changes is Docket No. 16-0310-0705.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because it confers benefits to Medicaid participants on the Basic Plan.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted since this rulemaking is being done to implement the selective contract for dental services.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Arla Farmer at (208) 364-1958.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, November 28, 2007.

DATED this 13th day of September, 2007.

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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

004. INCORPORATION BY REFERENCE.
The following are incorporated by reference in this chapter of rules: (3-30-07)

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations internet site at http://www.access.gpo.gov/nara/cfr/cfr-table-search.html. (3-30-07)

02. American Academy of Pediatrics (AAP) Periodicity Schedule. This document is available on the internet at: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf. The schedule is also available at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (3-30-07)

03. CDC Child and Teen BMI Calculator. The Centers for Disease Control (CDC) Child and Teen Body Mass Index (BMI) Calculator is available on the internet at: http://www.cdc.gov/nccdphp/dnpa/bmi/index.htm. The Calculator is also available through the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (3-30-07)

~~***04. CDT – 2005**. Current Dental Terminology, Fifth Edition. CDT - 2005. Current Dental Terminology, Fifth Edition, is available from the American Dental Association, 211 East Chicago Ave., Chicago, IL 60611-2678, or may be ordered online at http://www.ada.org/prof/resources/topics/cdt/manual.asp. A copy is available for public review at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705.* (3-30-07)~~

05~~4~~. DSM-IV-TR. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (3-30-07)

06~~5~~. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 East Chicago Avenue, Chicago, IL, 60611. (3-30-07)

07~~6~~. Idaho Infant Toddler Program Implementation Manual (Revised September 1999). The full text of the "Idaho Infant Toddler Program Implementation Manual," revised September 1999, is available at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (3-30-07)

08~~7~~. Idaho Special Education Manual, September 2001. The full text of the "Idaho Special Education Manual, September 2001" is available on the Internet at http://www.sde.state.id.us/SpecialEd/manual/sped.asp. A copy is also available at the Idaho Department of Education, 650 West State Street, P.O. Box 83720, Boise, Idaho 83720-0027. (3-30-07)

09~~8~~. Medicare Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Jurisdiction D Supplier Manual 2007, As Amended. Since the supplier manual is amended on a quarterly basis by CMS, the current year's manual is being incorporated by reference, as amended, to allow for the incorporation of the most recent amendments to the manual. The full text of the Medicare. DME MAC Jurisdiction D Supplier Manual is available via the Internet at: www.noridianmedicare.com. (3-30-07)

10~~1~~09. Physician's Current Procedural Terminology (CPT® Manual). This document may be obtained from the American Medical Association, P.O. Box 10950, Chicago, Illinois 60610, or online at: http://www.ama-assn.org/ama/pub/category/3113.html. (3-30-07)

11~~0~~. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available on the CMS internet site at http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID= CMS021929 and http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=0&sortBy DID=1&sortOrder=ascending&itemID=CMS021935. (3-30-07)

12~~1~~1. SIB-R Comprehensive Manual. Scales of Independent Behavior - Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL

60143-2079. A copy is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho 83702. (3-30-07)

1~~3~~2. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.idaho.gov. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.
Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits described in this chapter of rules. Those individuals eligible for services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," are also eligible for the services covered under this chapter of rules, unless specifically exempted. (3-30-07)

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 447 of these rules. (3-30-07)

a. Inpatient Hospital Services are described in Sections 400 through 406. (3-30-07)

b. Outpatient Hospital Services are described in Sections 410 through 416. (3-30-07)

c. Reconstructive Surgery services are described in Sections 420 through 426. (3-30-07)

d. Surgical procedures for weight loss are described in Sections 430 through 436. (3-30-07)

e. Investigational procedures or treatments are described in Sections 440 through 446. (3-30-07)

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 456 of these rules. (3-30-07)

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 516 of these rules. (3-30-07)

a. Physician services are described in Sections 500 through 506. (3-30-07)

b. Abortion procedures are described in Sections 510 through 516. (3-30-07)

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 556 of these rules. (3-30-07)

a. Midlevel practitioner services are described in Sections 520 through 526. (3-30-07)

b. Chiropractic services are described in Sections 530 through 536. (3-30-07)

c. Podiatrist services are described in Sections 540 through 546. (3-30-07)

d. Optometrist services are described in Sections 550 through 556. (3-30-07)

05. Primary Care Case Management. Primary Care Case Management services are described in Sections 560 through 56**6** of these rules**.** (3-30-07)

06. Prevention Services. The range of prevention services covered is described in Sections 570 through 646 of these rules. (3-30-07)

a. Health Risk Assessment services are described in Sections 570 through 576. (3-30-07)

b. Child wellness services are described in Sections 580 through 586. (3-30-07)

c. Adult physical services are described in Sections 590 through 596. (3-30-07)

d. Screening mammography services are described in Sections 600 through 606. (3-30-07)

e. Diagnostic Screening Clinic services are described in Sections 610 through 616. (3-30-07)

f. Personal Health Account services are described in Sections 620 through 626. (3-30-07)

g. Nutritional services are described in Sections 630 through 636. (3-30-07)

h. Diabetes Education and Training services are described in Sections 640 through 646. (3-30-07)

07. Laboratory and Radiology Services. Laboratory and radiology services are described in Sections 650 through 656 of these rules. (3-30-07)

08. Prescription Drugs. Prescription drug services are described in Sections 660 through 666 of these rules. (3-30-07)

09. Family Planning. Family planning services are described in Sections 680 through 686 of these rules. (3-30-07)

10. Mental Health Services. The range of covered Mental Health services are described in Sections 700 through 716 of these rules. (3-30-07)

a. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-30-07)

b. Mental Health Clinic services are described in Sections 707 through 718. (3-30-07)

11. Home Health Services. Home health services are described in Sections 720 through 726 of these rules. (3-30-07)

12. Therapies. Physical therapy services are described in Sections 730 through 736 of these rules. Speech and Occupational Therapy services are referred to in Section 738 of these rules. (3-30-07)

13. Speech Language and Hearing Services. Audiology services are described in Sections 740 through 746 of these rules. (3-30-07)

14. Durable Medical Equipment and Supplies. The range of covered durable medical equipment and supplies is described in Sections 750 through 776 of these rules. (3-30-07)

a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (3-30-07)

b. Oxygen and related equipment and supplies are described in Sections 760 through 766. (3-30-07)

c. Prosthetic and orthotic services are described in Sections 770 through 776. (3-30-07)

15. Vision Services. Vision services are described in Sections 780 through 786 of these rules. (3-30-07)

16. Dental Services. The ~~*range of covered*~~ dental ~~*and denturist*~~ services ~~*is*~~ covered under the Basic Plan are covered under a selective contract as described in Section~~s~~ 800 ~~*through 806*~~ of these rules. ~~*(3-30-07)*~~(9-1-07)T

17. Essential Providers. The range of covered essential services is described in Sections 820 through 856 of these rules. (3-30-07)

a. Rural health clinic services are described in Sections 820 through 826. (3-30-07)

b. Federally Qualified Health Center services are described in Sections 830 through 836. (3-30-07)

c. Indian Health Services Clinic services are described in Sections 840 through 846. (3-30-07)

d. School-Based services are described in Sections 850 through 856. (3-30-07)

18. Transportation. The range of covered transportation services is described in Sections 860 through 876 of these rules. (3-30-07)

a. Emergency transportation services are described in Sections 860 through 866. (3-30-07)

b. Non-emergency transportation services are described in Sections 870 through 876. (3-30-07)

19. EPSDT Services. EPSDT services are described in Sections 880 through 886 of these rules. (3-30-07)

20. Specific Pregnancy-Related Services. Specific pregnancy-related services are described in Sections 890 through 896 of these rules. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

800. ~~*DENTAL SERVICES -- DEFINITIONS*~~ SELECTIVE CONTRACT FOR DENTAL COVERAGE UNDER THE BASIC PLAN.
~~*Dental services are provided for the relief of dental pain, prosthetic replacement, and the correcting of handicapping malocclusion and are purchased from a licensed dentist or denturist.*~~ ~~*(3-30-07)*~~

01. Dental Coverage Under the Selective Contract. Children and adults under the Medicaid Basic Plan are covered under a selective contract with Blue Cross of Idaho for preventative dental visits, treatments, and restorative services. For more details on covered dental services, go to http://www.bcidaho.com/about_us/idaho_smiles.asp. (9-1-07)T

02. Limitations on Orthodontics. Orthodontics are limited to participants from birth to twenty-one (21) years of age who meet the eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant. The Malocclusion Index may be found in the Appendix A of these rules. (9-1-07)T

801. DENTAL SERVICES -- PARTICIPANT ELIGIBILITY.

***01. Children's Services**. Covered dental services for children (through the month of their twenty-first birthday) are covered in Sections 800 through 805 of these rules. (3-30-07)*

***02. Pregnancy-Related Services**. Dental services for women on the Pregnant Women (PW) Program are listed in Subsection 802.14 of these rules. (3-30-07)*

***03. Adult Coverage**. Covered dental services for Medicaid eligible adults (persons who are past the month of their twenty-first birthday) who are not eligible under PW or Qualified*

~~*Medicare Beneficiary (QMB) are listed in Subsection 802.15 of these rules.* (3-30-07)~~

~~***04. Orthodontics**. Limited to participants age zero (0) to twenty-one (21) years who meet the eligibility requirements, and the Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant. Participants already in orthodontic treatment who transfer to Idaho Medicaid must have their continuing treatment justified and authorized by the state Medicaid dental consultant.* (3-30-07)~~

~~***05. Participants Eligible for Other Programs**. Participants who have only Qualified Medicare Beneficiary (QMB) eligibility are not eligible for dental services.* (3-30-07)~~

~~***802. DENTAL SERVICES - COVERAGE AND LIMITATIONS.***~~

~~***01. Covered Dental Services**. Dental services are covered by Medicaid as described in Section 801 of these rules. Idaho uses the procedure codes contained in the Current Dental Terminology (CDT) handbook published by the American Dental Association.* (3-30-07)~~

~~***02 Non-Covered Services**. Non-covered services are procedures not recognized by the American Dental Association (ADA) or services not listed in these rules.* (3-30-07)~~

~~***03. Diagnostic Dental Procedures**.~~

~~***TABLE 802.03 - DENTAL DIAGNOSTIC PROCEDURES***~~	
~~***Dental Code***~~	~~***Description***~~
~~*a. General Oral Evaluations. The following evaluations are not allowed in combination of the same day:*~~	
~~*D0120*~~	~~*Periodic oral evaluation. Includes periodontal screening. One (1) periodic examination is allowed every six (6) months.*~~
~~*D0140*~~	~~*Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem. Not to be used when a participant returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.*~~
~~*D0150*~~	~~*Comprehensive oral evaluation. One (1) comprehensive examination is allowed every twelve (12) months. Six (6) months must elapse before a periodic exam can be paid.*~~
~~*D0160*~~	~~*Detailed and extensive oral evaluation. A detailed and extensive problem focused evaluation that entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. One (1) detailed and extensive oral evaluation is allowed every twelve (12) months.*~~
~~*D0170*~~	~~*Re-evaluation, limited, problem focused. Established participant, not post-operative visit.*~~
~~*b. Radiographs/Diagnostic Images.*~~	
~~*D0210*~~	~~*Intraoral - complete series (including bitewings). Complete series x-rays are allowed only once in a three-year period. A complete intraoral series consists of fourteen (14) periapicals and one (1) series of four (4) bitewings.*~~
~~*D0220*~~	~~*Intraoral periapical - first film.*~~

TABLE 802.03 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	**Description**
D0230	Intraoral periapical - each additional film.
D0240	Intraoral occlusal film.
D0270	Bitewing - single film. Total of four (4) bitewings allowed every six (6) months.
D0272	Bitewings - two (2) films. Total of four (4) bitewings allowed every six (6) months.
D0274	Bitewings - four (4) films. Total of four (4) bitewings allowed every six (6) months.
D0277	Vertical bitewings. Seven (7) to eight (8) films. Allowed every six (6) months.
D0330	Panoramic film. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a thirty-six-month period. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to four bitewings or periapicals are allowed in addition to a panoramic film.
D0340	Cephalometric film. Allowed once in a twelve-month period.
c. Test And Laboratory Examination.	
D0460	Pulp vitality tests. Includes multiple teeth and contralateral comparison(s) as indicated. Allowed once per visit per day.
D0470	Diagnostic casts.
d. Diagnostic.	
D0999	Unspecified diagnostic procedure, by report. Narrative required when prior authorizing.

(3-30-07)

04. Dental Preventive Procedures. Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis.

TABLE 802.04 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	**Description**
a. Dental Prophylaxis.	
D1110	Prophylaxis - Adult (twelve (12) years of age and older). A prophylaxis is allowed once every six (6) months. Includes polishing procedures to remove coronal plaque, calculus, and stains.
D1120	Prophylaxis - Children/young adult (under age twelve (12)). A prophylaxis is allowed once every six (6) months.
b. Fluoride Treatments.	
D1203	Topical application of fluoride - one (1) treatment. Prophylaxis not included. Allowed once every six (6) months for participants under age twenty (21).
D1204	Topical application of fluoride - adult, twenty-one (21) years of age and over. Prophylaxis not included. Allowed once every six (6) months.
c. Other Preventive Services.	

TABLE 802.04 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	**Description**
D1351	Sealant - per tooth. Mechanically and/or chemically prepared enamel surface. Allowed for participants under twenty-one (21) years of age. Limited to once per tooth every three (3) years. Tooth designation required.
d. Space Management Therapy. Space maintainers are allowed to hold space for missing teeth for participants under age twenty-one (21). No reimbursement is allowed for removing maintainers, unless by dentist other than providing dentist. Vertical space maintainers are not covered.	
D1510	Space maintainer - fixed - unilateral. Limited up to age twenty-one (21). Only allowed once per tooth space. Tooth space designation required.
D1515	Space maintainer - fixed - bilateral. Limited up to age twenty-one (21). Only allowed once per arch. Arch designation required.
D1520	Space maintainer, removable - unilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1525	Space maintainer, removable - bilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1550	Re-cementation of space maintainer. Limited up to age twenty-one (21). Only allowed once per quadrant or arch. Quadrant or arch designation required.

(3-30-07)

05. Restorations. (3-30-07)

a. Posterior Restoration. (3-30-07)

i. A one (1) surface posterior restoration is one in which the restoration involves only one (1) of the five (5) surface classifications: mesial, distal, occlusal, lingual, or facial (including buccal or labial). (3-30-07)

ii. A two (2) surface posterior restoration is one in which the restoration extends to two (2) of the five (5) surface classifications. (3-30-07)

iii. A three (3) surface posterior restoration is one in which the restoration extends to three (3) of the five (5) surface classification surface classifications. (3-30-07)

iv. A four (4) or more surface posterior restoration is one in which the restoration extends to four (4) or more of the five (5) surface classifications. (3-30-07)

b. Anterior Proximal Restoration. (3-30-07)

i. A one (1) surface anterior proximal restoration is one in which neither the lingual nor facial margin of the restoration extends beyond the line angle. (3-30-07)

ii. A two (2) surface anterior proximal restoration is one in which either the lingual

or facial margin of the restoration extends beyond the line angle. (3-30-07))

iii. A three (3) surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle. (3-30-07)

iv. A four (4) or more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved. (3-30-07)

***c.** Amalgams and Resin Restoration. (3-30-07)*

i. Reimbursement for pit restoration is allowed as a one (1) surface restoration. (3-30-07)

ii. Adhesives (bonding agents), bases, and the adjustment and/or polishing of sealant and restorations are included in the allowance for the major restoration. (3-30-07)

iii. Liners and bases are included as part of the restoration. If pins are used, they should be reported separately. (3-30-07)

***d.** Crowns. (3-30-07)*

i. When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required. (3-30-07)

ii. Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification. (3-30-07)

TABLE 802.05 - RESTORATIONS	
Dental Code	***Description***
e. Amalgam Restorations.	
D2140	*Amalgam - one (1) surface, primary or permanent. Tooth designation required.*
D2150	*Amalgam - two (2) surfaces, primary or permanent. Tooth designation required.*
D2160	*Amalgam - three (3) surfaces, primary or permanent. Tooth designation required.*
D2161	*Amalgam - four (4) or more surfaces, primary or permanent. Tooth designation required.*
f. Resin Restorations. Resin refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid etching, and adhesives (including resin bonding agents) are part of the restoration. Report glass ionomers when used as restorations. If pins are used, report them separately.	
D2330	*Resin - one (1) surface, anterior. Tooth designation required.*
D2331	*Resin - two (2) surfaces, anterior. Tooth designation required.*
D2332	*Resin - three (3) surfaces, anterior. Tooth designation required.*
D2335	*Resin - four (4) or more surfaces or involving incisal angle, anterior. Tooth designation required.*
D2390	*Resin based composite crown, anterior, primary or permanent. Tooth designation required.*

TABLE 802.05 - RESTORATIONS	
Dental Code	**Description**
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
g. Crowns.	
D2710	Crown resin indirect. Tooth designation required. Prior authorization required.
D2721	Crown resin with predominantly base metal. Tooth designation required. Prior authorization required.
D2750	Crown, porcelain fused to high noble metal. Tooth designation required. Prior authorization required.
D2751	Crown porcelain fused too predominantly base metal. Tooth designation required. Prior authorization required.
D2752	Crown, porcelain fused to noble metal. Tooth designation required. Prior authorization required.
D2790	Crown, full cast, high noble metal. Tooth designation required. Prior authorization required.
D2791	Crown full cast predominantly base metal. Tooth designation required. Prior authorization required.
D2792	Crown, full cast noble metal. Tooth designation required. Prior authorization required.
h. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
D2930	Prefabricated stainless steel crown - primary tooth. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth. Tooth designation required.
D2932	Prefabricated resin crown. Tooth designation required.
D2940	Sedative filling. Tooth designation required. Surface is not required.
D2950	Core buildup, including any pins. Tooth designation required. Limited to two (2) pins per tooth.
D2951	Pin retention - per tooth, in addition to restoration. Tooth designation required. Limited to two (2) pins per tooth.
D2954	Prefabricated post and core in addition to crown. Tooth designation required.
D2955	Post removal. Tooth designation required.
D2980	Crown repair. Tooth designation required.
D2999	Unspecified restorative procedure, by report. Narrative and tooth designation required when prior authorizing. Requires prior authorization.

(3-30-07)

06. Endodontics. *Pulpotomies and root canal procedures cannot be paid with the same date of service for the same tooth.*

TABLE 802.06 - ENDODONTICS	
Dental Code	**Description**
a. Pulp Capping.	
D3110	Pulp cap - direct (excluding final restoration). Tooth designation required.
b. Pulpotomy.	
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required. Not to be construed as the first stage of root canal therapy.
D3221	Pulpal debridement, primary & permanent teeth. For relief of acute pain not to be construed as the first stage of root canal therapy. Not allowed same day as endodontic therapy. Tooth designation required.
c. Root Canal Therapy. Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Root canal therapy (includes treatment plan, x-rays, clinical procedures and follow-up care) is for permanent teeth only. Separate charges are allowable for open and drain if the procedure is done on different days.	
D3310	Anterior (excluding final restoration). Tooth designation required.
D3320	Bicuspid (excluding final restoration). Tooth designation required.
D3330	Molar (excluding final restoration). Tooth designation required.
D3346	Retreatment of previous root canal therapy, anterior. Tooth designation required.
D3347	Retreatment of previous root canal therapy, bicuspid. Tooth designation required.
D3348	Retreatment of previous root canal therapy, molar. Tooth designation required.
d. Apicoectomy/Periradicular Services.	
D3410	Apicoectomy/Periradicular surgery-anterior surgery or root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.
D3421	Apicoectomy/Periradicular surgery-bicuspid (first root). Surgery on one root of a bicuspid does not include placement of retrograde filling material. Tooth designation required.
D3425	Apicoectomy/Periradicular surgery-Molar (first root). Does not include placement of retrograde filling material. Tooth designation required.
D3426	Apicoectomy/Periradicular surgery (each additional root). For molar surgeries when more than one root is being treated during the same procedure. Does not include retrograde filling material placement. Tooth designation required.
D3430	Retrograde filling - per root. For placement of retrograde filling material during Periradicular surgery procedures. Tooth designation required.
D3999	Unspecified restorative procedure, by report. Narrative and tooth designation required. Requires prior authorization.

(3-30-07)

07. Periodontics.

TABLE 802.07 - PERIODONTICS	
Dental Code	**Description**
a. Surgical Services.	
D4210	Gingivectomy or gingivoplasty - four (4) or more contiguous teeth in quadrant. Quadrant designation required.
D4211	Gingivectomy or gingivoplasty - one (1) to three (3) teeth in quadrant. Quadrant designation required.
b. Non-Surgical Periodontal Services.	
D4320	Provisional splinting - intracoronal.
D4321	Provisional splinting - extracoronal.
D4341	Periodontal scaling and root planing four (4) or more contiguous teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. Allowed once in a twelve (12) month period. The removal of subgingival and/or supragingival plaque and calculus. This is a preliminary procedure and does not preclude the need for other procedures.
c. Other Periodontal Services.	
D4910	Periodontal maintenance procedures. Allowed once in a three (3) month period. This procedure is for participants who have completed periodontal treatment (surgical and/or non-surgical periodontal therapies exclusive of D4355) and includes removal of the bacterial flora from crevicular and pocket areas, scaling and polishing of the teeth, periodontal evaluation, and a review of the participant's plaque control efficiency.
D4999	Unspecified periodontal procedure. Narrative required when prior authorizing. Requires prior authorization.

(3-30-07)

08. Prosthodontics. *(3-30-07)*

a. *Removable Prosthodontics.* *(3-30-07)*

i. The Medicaid dental program covers only one (1) set of full dentures in a five (5) year period. Full dentures placed immediately must be of structure and quality to be considered the final set. Transitional or interim treatment dentures are not covered. No additional reimbursements are allowed for denture insertions. *(3-30-07)*

ii. If full dentures are inserted during a month when the participant is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed. *(3-30-07)*

~~*iii. Medicaid pays for partial dentures once every five (5) years. Partial dentures are limited to participants age twelve (12) and older. One (1) partial per arch is covered. When a partial is inserted during a month when the participant is not eligible but all other work, including laboratory work, is completed during an eligible period, the claim for the partial is allowed.* (3-30-07)~~

***b. Removable Prosthodontics by Codes*.**

TABLE 802.08.b. - PROSTHODONTICS	
Dental Code	***Description***
i. Complete Dentures. This includes six (6) months of adjustments following placement.	
D5110	*Complete denture - maxillary.*
D5120	*Complete denture - mandibular.*
D5130	*Immediate denture - maxillary.*
D5140	*Immediate denture - mandibular.*
ii. *Partial Dentures. This includes six (6) months of care following placement. Limited to twelve (12) years and older.*	
D5211	*Maxillary partial denture - resin base. Includes any conventional clasps, rests, and teeth.*
D5212	*Mandibular partial denture - resin base. Includes any conventional clasps, rests, and teeth.*
D5213	*Maxillary partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.*
D5214	*Mandibular partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.*
iii. *Adjustments To Complete And Partial Dentures. No allowance for adjustments for six (6) months following placement. Adjustments done during this period are included in complete/partial allowance.*	
D5410	*Adjust complete denture - maxillary.*
D5411	*Adjust complete denture - mandibular.*
D5421	*Adjust partial denture - maxillary.*
D5422	*Adjust partial denture - mandibular.*
iv. *Repairs To Complete Dentures.*	
D5510	*Repair broken complete denture base. Arch designation required.*
D5520	*Replace missing or broken teeth - complete denture (each tooth) - six (6) tooth maximum. Tooth designation required.*
v. *Repairs To Partial Dentures.*	
D5610	*Repair resin denture base. Arch designation required.*
D5620	*Repair cast framework. Arch designation required.*
D5630	*Repair or replace broken clasp. Arch designation required.*
D5640	*Replace broken teeth, per tooth. Tooth designation required.*

TABLE 802.08.b. - PROSTHODONTICS	
Dental Code	**Description**
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture. Involves clasp or abutment tooth.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
vi. Denture Relining. Relines will not be allowed for six (6) months following placement of denture and then only once every two (2) years.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
vii. Other Removable Prosthetic Services.	
D5850	Tissue conditioning, maxillary - per denture unit.
D5851	Tissue conditioning, mandibular per denture unit.
D5899	Unspecified removable prosthetic procedure, by report. Narrative required when prior authorizing. Requires prior authorization.
D5899	Unable to deliver full or partial denture. Prior authorization required. If the participant does not complete the process for the denture; leaves the state; cannot be located; or dies; the laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

(3-30-07)

09. Maxillo-Facial Prosthetics.

TABLE 802.09 - MAXILLO-FACIAL PROSTHETICS	
Dental Code	Description
D5931	Obturator prosthesis, surgical. Narrative required when prior authorizing. Requires prior authorization.
D5932	Obturator prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.
D5933	Obturator prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.

TABLE 802.09 - MAXILLO FACIAL PROSTHETICS	
D5934	Mandibular resection prosthesis with guide flange. Narrative required when prior authorizing. Requires prior authorization.
D5935	Mandibular resection prosthesis without guide flange. Narrative required when prior authorizing. Requires prior authorization.
D5936	Obturator prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.
D5951	Feeding aid. Narrative required when prior authorizing. Requires prior authorization.
D5952	Speech aid prosthesis, pediatric. Narrative required when prior authorizing. Requires prior authorization.
D5953	Speech aid prosthesis, adult. Narrative required when prior authorizing. Requires prior authorization.
D5954	Palatal augmentation prosthesis. Narrative required when prior authorizing. Requires prior authorization.
D5955	Palatal lift prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.
D5958	Palatal lift prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.
D5959	Palatal life prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5960	Speech aid prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5982	Surgical stent. Narrative required when prior authorizing. Requires prior authorization.
D5988	Surgical splint. Narrative required when prior authorizing. Requires prior authorization.
D5999	Unspecified maxillofacial prosthesis. Narrative required when prior authorizing. Requires prior authorization.

(3-30-07)

10. Fixed Prosthodontics.

TABLE 802.10 - FIXED PROSTHODONTICS	
Dental Code	**Description**
Other Fixed Prosthetic Services.	
D6930	Re-cement fixed partial denture.
D6980	Fixed partial denture repair.
D6999	Unspecified fixed prosthodontic procedure, by report. Narrative required when prior authorizing Requires prior authorization.

(3-30-07)

11. Oral Surgery.

TABLE 802.11 - ORAL SURGERY	
Dental Code	**Description**
a. Simple Extraction.	
D7111	Extraction, coronal remnants - deciduous tooth. Including soft tissue retained coronal remnants.
D7140	Extraction, erupted tooth or exposed root, routine removal.
b. Surgical Extractions.	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, and closure. Tooth designation required.
D7220	Removal of impacted tooth - soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth -- partially bony. Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7240	Removal of impacted tooth - completely bony. Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications. Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Allowed only when pathology is present. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of gingiva and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.
c. Other Surgical Procedures.	
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus. Tooth designation required. Includes splinting and/or stabilization.
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons. Includes orthodontic attachments. Tooth designation required. Limited to participants under twenty-one (21) years of age.
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption. Tooth designation required. Limited to participants under twenty-one (21) years of age.
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
D7287	Cytology sample collection via mild scraping of oral mucosa.
d. Alveoloplasty.	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant. Quadrant designation is required.
e. Excision of Bone Tissue.	
D7471	Removal of lateral exostosis. Maxilla or mandible. Arch designation required.
f. Surgical Incision.	

TABLE 802.11 - ORAL SURGERY	
Dental Code	**Description**
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
g. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
h. Other Repair Procedures.	
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure. The frenum may be excised when the tongue has limited mobility; for large diastema between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.
D7970	Excision of hyperplastic tissue - per arch. Arch designation required.
D7971	Excision of pericoronal gingiva. Arch designation required.
D7999	Unspecified oral surgery, by report. Narrative required when prior authorizing. Requires prior authorization.

(3-30-07)

12. Orthodontics.

TABLE 802.12 - ORTHODONTICS	
Dental Code	**Description**
a. Limited Orthodontics. Orthodontic treatment with a limited objective, not involving the entire dentition may be directed at the only existing problem, or one aspect of a larger problem in which a decision is made to defer or forgo more comprehensive therapy.	
D8010	Limited orthodontic treatment of primary dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8020	Limited orthodontic treatment of transitional dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8030	Limited orthodontic treatment of adolescent dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8040	Limited orthodontic treatment of adult dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
b. Comprehensive Orthodontic Treatment. The coordinated diagnosis and treatment leading to the improvement of a participant's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances, and can also include removable appliances, headgear, and maxillary expansion procedures. Must score at least eight (8) points on the State's Handicapping Malocclusion Index.	
D8070	Comprehensive orthodontic treatment of transition dentition. Models, panorexes, and treatment plan are required when prior authorizing. Requires prior authorization.

TABLE 802.12 - ORTHODONTICS	
Dental Code	**Description**
D8080	Comprehensive orthodontic treatment of adolescent dentition, up to sixteen (16) years of age. Models, panorexes, and treatment plan are required when prior authorizing. Requires prior authorization.
D8090	Comprehensive orthodontic treatment of adult dentition. Justification required. Models, panoramic film, and treatment plan are required when prior authorizing. Requires prior authorization.
c. Minor Treatment to Control Harmful Habits.	
D8210	Removable appliance therapy. Removable indicates participant can remove; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.
D8220	Fixed appliance therapy. Fixed indicates participant cannot remove appliance; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.
d. Other Services.	
D8670	Adjustments monthly. When utilizing treatment codes D8050, D8060, D8070, D8080 or D8090 a maximum of twenty-four (24) adjustments over two (2) years will be allowed (twelve (12) per year) when prior authorizing. When utilizing treatment codes D8210 or D8220, two (2) adjustments will be allowed per treatment when prior authorizing. Requires prior authorization.
D8680	Orthodontic retention, removal of appliances, construction and placement of retainer(s). Replacement appliances are not covered. Includes both upper and lower retainer if applicable.
D8691	Repair of orthodontic appliance. Limited to one (1) occurrence.
D8999	Unspecified orthodontics. Narrative required when prior authorizing. No payment for lost or destroyed appliances. Requires prior authorization.

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13. Adjunctive General Services.

TABLE 802.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
a. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain minor procedure (open and drain abscess, etc.). Open and drain is included in the fee for root canal when performed during the same sitting. Tooth or quadrant designation required.
b. Anesthesia.	
D9220	Deep sedation/general anesthesia first thirty (30) minutes. Not included as general anesthesia are tranquilization; nitrous oxide; or enteral or parenteral administration of analgesic, sedative, tranquilizing, or dissociative agents.
D9221	Deep sedation/general anesthesia each additional fifteen (15) minutes.

~~*TABLE 802.13 - ADJUNCTIVE GENERAL SERVICES*~~	
~~***Dental Code***~~	~~***Description***~~
~~*D9230*~~	~~*Analgesia - includes nitrous oxide.*~~
~~*D9241*~~	~~*Intravenous conscious sedation/analgesia first thirty (30) minutes. Provider certification required.*~~
~~*D9242*~~	~~*Intravenous conscious sedation/analgesia each additional fifteen (15) minutes. Provider certification required.*~~
~~*c. Professional Consultation.*~~	
~~*D9310*~~	~~*Consultation. Provided by dentist or physician whose opinion or advice regarding the evaluation, management and/or treatment of a specific problem or condition is requested by another dentist or physician. The written or verbal request for a consult must be documented in the participant's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant's medical record and communicated to the requesting dentist or physician. A dental consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.*~~
~~*d. Professional Visits.*~~	
~~*D9410*~~	~~*House/Extended Care Facility Calls. Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per participant. To be used when participant's health restrictions require treatment at the house/extended care facility.*~~ ~~*If procedures are done in the hospital, use procedure code D9420.*~~
~~*D9420*~~	~~*Hospital Calls. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited once per day per participant. Not covered for routine preoperative and postoperative. If procedures are done in other than hospital or surgery center use procedure code D9410 found in this table.*~~
~~*D9430*~~	~~*Office visit for observation (during regularly scheduled hours). No other services performed.*~~
~~*D9440*~~	~~*Office visit after regularly scheduled hours.*~~
~~*e. Miscellaneous Service.*~~	
~~*D9920*~~	~~*Behavior Management. May be reported in addition to treatment provided when the participant is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. Notation and justification must be written in the participant's record identifying the specific behavior problem and the technique used to manage it. Allowed once per participant per day.*~~
~~*D9930*~~	~~*Treatment of complication (post-surgical) - unusual circumstances.*~~
~~*D9940*~~	~~*Occlusal guards - removable dental appliances which are designed to minimize the effects of bruxism (tooth grinding) and other occlusal factors. No payment for replacement of lost or destroyed appliances.*~~
~~*D9951*~~	~~*Occlusal adjustment, limited. May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a per-visit basis. Allowed once every twelve (12) months.*~~

TABLE 802.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
D9952	Occlusal adjustment, complete. Occlusal adjustment may require several appointments of varying length and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be used for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma, when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma. Justification required when prior authorizing. Requires prior authorization.
D9999	Unspecified adjunctive procedure, by report. Narrative required when prior authorizing. Requires prior authorization.

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14. Pregnant Women (PW) Codes. The following are the only codes covered for women on the Pregnant Women program.

TABLE 802.14 - PREGNANT WOMEN CODES	
Dental Code	**Description**
a. Clinical Oral Examinations.	
D0140	Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem.
b. Radiographs.	
D0220	Intraoral - periapical - first film.
D0230	Intraoral - periapical - each additional film.
D0330	Panoramic film.
c. Restorative Services.	
D2940	Sedative filling. Tooth designation required.
d. Pulp Capping.	
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required.
e. Adjunctive Periodontal Services.	
D4341	Periodontal scaling, root planning, four (4) or more contiguous teeth per quadrant. Allowed once in a twelve-month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant. Allowed once in a twelve-month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis.
f. Oral Surgery. Extractions - includes local anesthesia and routine postoperative care.	
D7111	Extraction, coronal remnants - deciuous tooth. Including soft tissue retained coronal remnants.

TABLE 802.14 - PREGNANT WOMEN CODES	
Dental Code	**Description**
D7140	Extraction, erupted tooth or exposed root, routine removal.
g. Surgical. Extractions - includes local anesthesia and routine postoperative care.	
D7210	Surgical removal of an erupted tooth requiring elevation of the mucoperiosteal flap and removal of tooth structure, and closure. Tooth designation required.
D7220	Removal of impacted tooth - soft tissue. Tooth designation required.
D7230	Removal of impacted tooth - partially bony. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Tooth designation required.
h. Surgical Incision.	
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
i. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain - minor procedures.
j. Professional Consultation.	
D9310	Consultation. Provided by dentist or physician whose opinion or advice regarding the evaluation, management and/or treatment of a specific problem or condition is requested by another dentist or physician. The written or verbal request for a consult must be documented in the participant's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant's medical record and communicated to the requesting dentist or physician. A dental consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
k. Professional Visits.	
D9420	Hospital Call. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per participant.
D9440	Office visit - after regularly scheduled hours.
D9930	Treatment of complication (post-surgical) - unusual circumstances.

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15. Dental Codes For Adult Services. The following dental codes are covered for adults after the month of their twenty-first birthday.

TABLE 802.15 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
a. Dental Diagnostic Procedures. The definitions for these codes are in Subsection 802.03 of theses rules.	
i. General Oral Evaluations.	
D0120	Periodic oral evaluation.

~~***TABLE 802.15 - DENTAL CODES FOR ADULTS***~~	
~~***Dental Code***~~	~~***Description***~~
~~*D0140*~~	~~*Limited oral evaluation.*~~
~~*D0150*~~	~~*Comprehensive oral evaluation.*~~
~~*ii. Radiographs/Diagnostic Images.*~~	
~~*D0210*~~	~~*Intraoral - complete series.*~~
~~*D0220*~~	~~*Intraoral periapical - first film.*~~
~~*D0230*~~	~~*Intraoral periapical - each additional film.*~~
~~*D0270*~~	~~*Bitewing - single film.*~~
~~*D0272*~~	~~*Bitewings - two (2) films.*~~
~~*D0274*~~	~~*Bitewings - four (4) films.*~~
~~*D0277*~~	~~*Vertical bitewings - seven (7) to eight (8) films.*~~
~~*D0330*~~	~~*Panoramic film.*~~
~~*b. Dental Preventive Procedures.*~~ ~~*The definitions for these codes are in Subsection 802.04 of theses rules.*~~	
~~*i. Dental Prophylaxis.*~~	
~~*D1110*~~	~~*Prophylaxis - adult.*~~
~~*ii. Fluoride Treatments.*~~	
~~*D1204*~~	~~*Topical application of fluoride - prophylaxis not included - adult.*~~
~~*c. Dental Restorative Procedures.*~~ ~~*The definitions for these codes are in Subsection 802.05 of theses rules.*~~	
~~*i. Amalgam Restorations.*~~	
~~*D2140*~~	~~*Amalgam - one (1) surface, primary or permanent.*~~
~~*D2150*~~	~~*Amalgam - two (2) surfaces, primary or permanent.*~~
~~*D2160*~~	~~*Amalgam - three (3) surfaces, primary or permanent.*~~
~~*D2161*~~	~~*Amalgam - four (4) or more surfaces, primary or permanent.*~~
~~*ii. Resin Restorations.*~~	
~~*D2330*~~	~~*Resin - one (1) surface, anterior.*~~
~~*D2331*~~	~~*Resin - two (2) surfaces, anterior.*~~
~~*D2332*~~	~~*Resin - three (3) surfaces, anterior.*~~
~~*D2335*~~	~~*Resin - four (4) or more surfaces or involving incisal angle, anterior.*~~
~~*D2390*~~	~~*Resin based composite crown, anterior, primary or permanent.*~~
~~*D2391*~~	~~*Resin based composite - one (1) surface, posterior, primary or permanent.*~~
~~*D2392*~~	~~*Resin based composite - two (2) surfaces, posterior, primary or permanent.*~~
~~*D2393*~~	~~*Resin based composite - three (3) surfaces, posterior, primary or permanent.*~~
~~*D2394*~~	~~*Resin based composite - four (4) surfaces, posterior, primary or permanent.*~~

~~***TABLE 802.15 - DENTAL CODES FOR ADULTS***~~	
~~***Dental Code***~~	~~***Description***~~
~~*iii. Other Restorative Services.*~~	
~~*D2920*~~	~~*Re-cement crown. Tooth designation required.*~~
~~*D2931*~~	~~*Prefabricated stainless steel crown - permanent tooth.*~~
~~*D2940*~~	~~*Sedative filling.*~~
~~*d. Endodontics.*~~ ~~*The definitions for these codes are in Subsection 802.06 of theses rules.*~~	
~~*D3220*~~	~~*Therapeutic pulpotomy.*~~
~~*D3221*~~	~~*Pulpal debridement, permanent teeth.*~~
~~*e. Periodontics.*~~ ~~*The definitions for these codes are in Subsection 802.07 of theses rules.*~~	
~~*i. Non-Surgical Periodontal Service.*~~	
~~*D4341*~~	~~*Periodontal scaling and root planing - four (4) or more contiguous teeth (per quadrant).*~~
~~*D4342*~~	~~*Periodontal scaling and root planing one (1) to three (3) teeth per quadrant.*~~
~~*D4355*~~	~~*Full mouth debridement.*~~
~~*ii. Other Periodontal Services.*~~	
~~*D4910*~~	~~*Periodontal maintenance procedures.*~~
~~*f. Prosthodontics.*~~ ~~*The definitions for these codes are in Subsection 802.08.b. of theses rules.*~~	
~~*i. Complete Dentures.*~~	
~~*D5110*~~	~~*Complete denture - maxillary.*~~
~~*D5120*~~	~~*Complete denture - mandibular.*~~
~~*D5130*~~	~~*Immediate denture - maxillary.*~~
~~*D5140*~~	~~*Immediate denture - mandibular.*~~
~~*ii. Partial Dentures.*~~	
~~*D5211*~~	~~*Maxillary partial denture - resin base.*~~
~~*D5212*~~	~~*Mandibular partial denture - resin base.*~~
~~*iii. Adjustments to Dentures.*~~	
~~*D5410*~~	~~*Adjust complete denture - maxillary.*~~
~~*D5411*~~	~~*Adjust complete denture - mandibular.*~~
~~*D5421*~~	~~*Adjust partial denture - maxillary.*~~
~~*D5422*~~	~~*Adjust partial denture - mandibular.*~~
~~*iv. Repairs to Complete Dentures.*~~	
~~*D5510*~~	~~*Repair broken complete denture base.*~~
~~*D5520*~~	~~*Replace missing or broken teeth - complete denture, each tooth.*~~

~~TABLE 802.15 - DENTAL CODES FOR ADULTS~~	
~~Dental Code~~	~~Description~~
~~v. Repairs to Partial Dentures.~~	
~~D5610~~	~~Repair resin denture base.~~
~~D5620~~	~~Repair cast framework.~~
~~D5630~~	~~Repair or replace broken clasp.~~
~~D5640~~	~~Replace broken teeth, per tooth.~~
~~D5650~~	~~Add tooth to existing partial denture.~~
~~D5660~~	~~Add clasp to existing partial denture.~~
~~D5670~~	~~Replace all teeth and acrylic on cast metal framework (maxillary).~~
~~D5671~~	~~Replace all teeth and acrylic on cast metal framework (mandibular).~~
~~vi. Denture Relining.~~	
~~D5730~~	~~Reline complete maxillary denture (chairside).~~
~~D5731~~	~~Reline complete mandibular denture (chairside).~~
~~D5740~~	~~Reline maxillary partial denture (chairside).~~
~~D5741~~	~~Reline mandibular partial denture (chairside).~~
~~D5750~~	~~Reline complete maxillary denture (laboratory).~~
~~D5751~~	~~Reline complete mandibular denture (laboratory).~~
~~D5760~~	~~Reline maxillary partial denture (laboratory).~~
~~D5761~~	~~Reline mandibular partial denture (laboratory).~~
~~g. Oral Surgery.~~ ~~The definitions for these codes are in Subsection 802.11 of theses rules.~~	
~~i. Extractions.~~	
~~D7111~~	~~Extraction, coronal remnants - deciduous tooth.~~
~~D7140~~	~~Extraction, erupted tooth or exposed root, routine removal.~~
~~ii. Surgical Extractions~~	
~~D7210~~	~~Surgical removal of erupted tooth.~~
~~D7220~~	~~Removal of impacted tooth - soft tissue.~~
~~D7230~~	~~Removal of impacted tooth -- partially bony.~~
~~D7240~~	~~Removal of impacted tooth - completely bony.~~
~~D7241~~	~~Removal of impacted tooth - completely bony, with unusual surgical complications.~~
~~D7250~~	~~Surgical removal of residual tooth roots.~~
~~iii. Other Surgical Procedures.~~	
~~D7286~~	~~Biopsy of oral tissue - soft. For surgical removal of specimen only.~~
~~iv. Surgical Incision.~~	

TABLE 802.15 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D7510	Incision and drainage of abscess - including periodontal origins.
v. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
vi. Other Repair Procedures.	
D7970	Excision of hyperplastic tissue.
D7971	Excision of pericoronal gingiva.
h. Adjunctive General Services. The definitions for these codes are in Subsection 802.13 of theses rules.	
i. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain.
ii. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes.
iii. Professional Consultation.	
D9310	Consultation requested by other dentist or physician.
iv. Professional Visits.	
D9410	House, institutional, or extended care facility calls.house/extended care facility.
D9420	Hospital calls.
D9440	Office visit after regularly scheduled hours.
D9930	Treatment of complication (post-surgical) - unusual circumstances.

(3-30-07)

16. Denturist Procedure Codes.

a. The following codes are valid denturist procedure codes:

TABLE 802.16.a. - DENTURIST PROCEDURE CODES	
Dental Code	**Description**
D5110	Complete denture, upper
D5120	Complete denture, lower
D5130	Immediate denture, upper

TABLE 802.16.a. - DENTURIST PROCEDURE CODES	
Dental Code	**Description**
D5140	Immediate denture, lower
D5410	Adjust complete denture, upper
D5411	Adjust complete denture, lower
D5421	Adjust partial denture, upper
D5422	Adjust partial denture, lower
D5510	Repair broken complete denture base; arch designation required.
D5520	Replace missing or broken teeth, complete denture (each tooth); six (6) teeth maximum. Tooth designation required.
D5610	Repair resin saddle or base; arch designation required.
D5620	Repair cast framework; arch designation required.
D5630	Repair or replace broken clasp; arch designation required.
D5640	Replace broken teeth per tooth; tooth designation required.
D5650	Add tooth to existing partial denture; tooth designation required.
D5660	Add clasp to existing partial denture; not requiring the altering of oral tissue or natural teeth. Tooth designation required.
D5730	Reline complete upper denture (chairside)
D5731	Reline complete lower denture (chairside)
D5740	Reline upper partial denture (chairside)
D5741	Reline lower partial denture (chairside)
D5750	Reline complete upper denture (laboratory)
D5751	Reline complete lower denture (laboratory)
D5760	Reline upper partial denture (laboratory)
D5761	Reline lower partial denture (laboratory)
D5899	Unable to deliver full denture. Prior authorization required. If the participant does not complete the process for the denture, leaves the state, cannot be located or dies, laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

(3-30-07)

b. Medicaid allows complete and immediate denture construction once every five (5) years. Denture reline is allowed once every two (2) years. Complete and partial denture adjustment is considered part of the initial denture construction service for the first six (6) months. (3-30-07)

803. DENTAL SERVICES - PROCEDURAL REQUIREMENTS.

01. Dental Prior Authorization. All procedures that require prior authorization must be approved by the Medicaid dental consultant prior to the service being rendered. Prior

~~*authorization requires written submission including diagnostics. Verbal authorizations will not be given. Retroactive authorization will be given only in an emergency situation or as the result of retroactive eligibility. Prior authorization of Medicaid dental procedures does not guarantee payment.* (3-30-07)~~

~~***02. Denturist Prior Authorization**. Prior authorization is not required for the dentist procedures except for dental code D5899 found in Subsection 802.16 of these rules.* (3-30-07)~~

~~***03. Crowns**.* (3-30-07)~~

~~***a.** When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required.* (3-30-07)~~

~~***b.** Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification.* (3-30-07)~~

~~***804. DENTAL SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.***~~
~~*All dental services must be documented in the participant's record to include: procedure, surface, and tooth number (if applicable). This record must be maintained for a period of six (6) years.* (3-30-07)~~

~~***805. DENTAL SERVICES - PROVIDER REIMBURSEMENT.***~~
~~*Medicaid reimburses dentists and denturists for procedures on a fee-for-service basis. Usual and customary charges are paid up to the Medicaid maximum allowance. Dentists may make arrangements for private payment with families for services not covered by Medicaid. If the provider accepts any Medicaid payment for a covered service, the Medicaid payment must be accepted as payment in full for the service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount.* (3-30-07)~~

80~~6~~1. -- 819. (RESERVED).

APPENDIX A

IDAHO MEDICAID HANDICAPPING MALOCCLUSION INDEX

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
Lower incisors: striking lingual of uppers at incisal	1/3 = 0	
Striking lingual of uppers at middle	1/3 = 1	
Striking lingual of uppers at gingival	1/3 = 2	
OPENBITE: (millimeters) *a,b		
Less than……	2 mm = 0	

OVERBITE:	**MEASUREMENT/POINTS:**	**SCORE:**
	2-4 mm = 1	
	4+ mm = 2	
OVERJET: (millimeters) *a		
Upper……..	2-4 mm = 0	
Measure horizontally parallel to occlusal plane.	5-9 mm = 1	
	9+ mm = 2	
Lower……..	0-1 mm = 0	
	2 mm = 1	
	3+ mm = 2	
POSTERIOR X-BITE: (teeth) *b		
Number of teeth in x-bite:	0-2 = 0	
	3 = 1	
	4 = 2	
TOOTH DISPLACEMENT: (teeth) *c, d, e		
Number of teeth rotated 45 degrees or displaced 2mm from normal position in arch.	0-2 = 0 3-6 = 1 7+ = 2	
BUCCAL SEGMENT RELATIONSHIP:		
One side distal or mesial ½ cusp	= 0	
Both sides distal or mesial or one side full cusp	= 1	
Both sides full cusp distal or mesial	= 2	

TOTAL SCORE: _____

Scoring Definitions:

a) Impacted **or** blocked cuspids are scored 1 open bite and 1 over jet for two teeth. Score 2 for open bite and 2 for over jet for 4 blocked cuspids.

b) Cross bites are scored for the teeth in cross bite, not the teeth in the opposing arch.

c) Missing teeth count as 1, if the space is still present.

d) Do not score teeth that are not fully erupted.

e) Displaced teeth are based on where they are in their respective arch line, not their relationship with the opposing arch.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0708

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2008.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections, 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; and Title XIX and Title XXI of the Social Security Act, as amended, and the companion federal regulations.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than December 19, 2007.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking is needed to allow physicians who provide mental health services to use the telehealth technology in locations of their choosing and utilize hospitals or other places where the equipment exists. This new rule allows physicians to bill Medicaid using their individual provider numbers for the delivery of telehealth services in these new locations. The rules will allow an additional service, Psychiatric Diagnostic Interview, to be delivered via telehealth technology, so that the entire telehealth package would then include evaluation/diagnosis, medication, and therapy.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

This rule confers a benefit to participants by opening up an avenue to mental health services that is not currently available.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

There will be a minimal fiscal impact due to this rule change. Travel costs for participants will be reduced by approximately $615 per year, while the cost of providing telehealth sessions will be approximately $520. This will produce a savings to Medicaid funds of approximately $95 per year. The Department estimates that thirteen episodes of psychiatric telehealth will be provided in 2008.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rulemaking clearly confers a benefit to Medicaid participants.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Diane Miller at (208) 364-1884.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before December 26, 2007.

DATED this 23th day of October, 2007.

Sherri Kovach, Program Supervisor
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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

500. PHYSICIAN SERVICES - DEFINITIONS.

01. Physician Services. ~~*The Department will reimburse for*~~ Physician services include the treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage contained in Section 390 and Subsection 502.01 of these rules. Physician services as defined in Subsection 500.01 of this rule will be reimbursed by the Department. ~~*(3-30-07)*~~(1-1-08)T

02. Psychiatric Telehealth. Psychiatric Telehealth is an electronic real time synchronous audio-visual contact between a physician and participant related to the treatment of the participant. The participant is in one (1) location, called the hub site, with specialized equipment including a video camera and monitor, and with the hosting provider. The physician is at another location, called the spoke site, with specialized equipment. The physician and participant interact as if they were having a face-to-face service. (1-1-08)T

501. (RESERVED).

502. PHYSICIAN SERVICES - COVERAGE AND LIMITATIONS.

01. Outpatient Psychiatric Mental Health Services. Outpatient psychiatric mental health services are limited to twelve (12) hours of psychiatric evaluations per eligible participant in any twelve (12) month period; and any combination of individual or group psychotherapy services provided by a physician up to a maximum of forty-five (45) hours of service in the consecutive twelve (12) months period beginning with the first such service. (3-30-07)

02. Sterilization Procedures. Particular restrictions pertaining to payment for sterilization procedures are contained in Sections 680 through 686 of these rules. (3-30-07)

03. Abortions. Restrictions governing payment for abortions are contained in Sections 511 through 514 of these rules. (3-30-07)

04. Tonometry. Payment for tonometry is limited to one (1) examination for individuals over the age of forty (40) years during any twelve (12) month period (in addition to tonometry as a component of examination to determine visual acuity). In the event examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. (3-30-07)

05. Physical Therapy Services. Payment for physical therapy services performed in the physician's office is limited to those services which are described and supported by the diagnosis. (3-30-07)

06. Injectable Vitamins. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. (3-30-07)

07. Corneal Transplants and Kidney Transplants. Corneal transplants and kidney transplants are covered by the Medical Assistance Program. (3-30-07)

08. Psychiatric Telehealth. Payment for telehealth services is limited to psychiatric services for diagnostic assessments, pharmacological management, and psychotherapy with evaluation and management services twenty (20) to thirty (30) minutes in duration. Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a physician and a participant. Service will not be reimbursed when provided via a videophone or webcam. (1-1-08)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0709

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2008.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also Title XIX and Title XXI of the Social Security Act, as amended, and the companion federal regulations.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than December 19, 2007.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Psychotherapy sessions with family or caregivers, without the participant being present, are often medically necessary for appropriate treatment of a psychiatric participant who is paranoid, agitated or physically aggressive. These rules have been amended to allow for family psychotherapy sessions without a participant being present. The other mental health services have been revised to reflect the appropriate use of these services to best collaborate and coordinate care regarding the participant's treatment. These types of interventions will help decrease the participant's distress, manage behavioral problems, improve caregiver safety, and avoid crises that require emergency interventions such as hospitalization. Evidence based practice has shown that the length of treatment is shortened when family therapy is one of the treatment services provided.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because it confers benefits to Medicaid participants on the Basic Plan.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

This rulemaking is anticipated to be cost neutral and will have no fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, formal negotiated rulemaking was not conducted but informal negotiations have been held with the Mental Health Providers' Association and other stakeholders.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Diane Miller at (208) 364-1844.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before December 26, 2007.

DATED this 15th day of October, 2007.

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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

710. MENTAL HEALTH CLINIC SERVICES - COVERAGE AND LIMITATIONS.
All mental health clinic services must be provided at the clinic unless provided to an eligible homeless individual. (3-30-07)

01. Clinic Services -- Mental Health Clinics (MHC). Under 42 CFR 440.90, the Department will pay for preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided by a mental health clinic to a participant who is not an inpatient in a hospital or nursing home or correctional facility except as specified under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 229. (3-30-07)

02. Services or Supplies in Mental Health Clinics That Are Not Reimbursed. Any service or supplies not included as part of the allowable scope of the Medical Assistance Program. (3-30-07)

03. Evaluation and Diagnostic Services in Mental Health Clinics. (3-30-07)

a. ~~*Social History.*~~ Social History is a reimbursable evaluation and diagnostic service. ~~*(3-30-07)*~~(1-1-08)T

b. ~~*Psychological Testing.*~~ Psychological testing may be provided as a reimbursable service when provided in direct response to a specific evaluation question. The psychological report must contain the reason for the performance of this service. Agency staff may deliver this service if they meet one (1) of the following qualifications: ~~*(3-30-07)*~~(1-1-08)T

i. Licensed Psychologist; (3-30-07)

ii. Psychologist extenders as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners"; or (3-30-07)

iii. A qualified therapist listed in Subsection 715.03 of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing. (3-30-07)

c. ~~***Psychiatric Diagnostic Interview Exam.***~~ A psychiatric diagnostic interview exam may be provided as a reimbursable service when delivered by one (1) of the following licensed professionals: ~~*(3-30-07)*~~(1-1-08)T

i. Psychiatrist; (3-30-07)

ii. Physician; (3-30-07)

iii. Practitioner of the healing arts; (3-30-07)

iv. Psychologist; (3-30-07)

v. Clinical Social Worker; (3-30-07)

vi. Clinical Professional Counselor; or (3-30-07)

vii. **Licensed Marriage and Family Therapist**. (3-30-07)

d. ~~*Evaluations Performed by Occupational Therapists.*~~ Evaluations performed by qualified registered occupational therapists, O.T.R., performed in conjunction with the development of an individualized treatment plan are reimbursable. ~~*(3-30-07)*~~(1-1-08)T

~~***04. Limitations.*** *A total of twelve (12) hours is the maximum time allowed for a combination of any evaluative or diagnostic services and individualized treatment plan development provided to an eligible participant in a calendar year.* *(3-30-07)*~~

0~~5~~4. Psychotherapy Treatment Services in Mental Health Clinics. ~~*(3-30-07)*~~

~~***a.*** *Psychotherapy.*~~ Individual and group psychotherapy must be provided in accordance with the goals specified in the individualized treatment plan as described in Section 709 of these rules. ~~*(3-30-07)*~~(1-1-08)T

***b*05. Family Psychotherapy**. Family psychotherapy services must *include at least the participant and one (1) family member and must* be delivered in accordance with the goals of treatment as specified in the individualized treatment plan. The focus of family psychotherapy is on the dynamics within the family structure as it relates to the participant. *(3-30-07)*(1-1-08)T

a. Family psychotherapy services with the participant present must: (1-1-08)T

i. Be face-to-face with at least one (1) family member present in addition to the participant; (1-1-08)T

ii. Focus the treatment services on goals identified in the participant's individualized treatment plan; and (1-1-08)T

iii. Utilize an evidence-based treatment model. (1-1-08)T

b. Family psychotherapy without the participant present must: (1-1-08)T

i. Be face-to-face with at least one (1) family member present; (1-1-08)T

ii. Focus the services on the participant; and (1-1-08)T

iii. Utilize an evidence-based treatment model. (1-1-08)T

***c*06. Emergency Psychotherapy Services**. Individual emergency psychotherapy services can be provided by qualified clinic staff at any time. *(3-30-07)*(1-1-08)T

***i*a.** Emergency services provided to an eligible participant prior to intake and evaluation is a reimbursable service but must be fully documented in the participant's record; and (3-30-07)

***ii*b.** Each emergency service will be counted as a unit of service and part of the allowable limit per participant unless the contact results in hospitalization. Provider agencies may submit claims for the provision of psychotherapy in emergency situations even when contact does not result in the hospitalization of the participant. (3-30-07)

0*6*7. Collateral Contact. Collateral contact, as defined in Section 010 of these rules, *will be* is covered by Medicaid *if it is conducted face to face by agency staff qualified to deliver clinical services, and* if it is included on the individualized treatment plan and it is necessary to gather and exchange information *with individuals having a primary relationship to*, provide interpretation or explanation of results of psychiatric evaluations, medical examinations and procedures, other accumulated data to family or other responsible persons, or advise them how to assist the participant. *(3-30-07)*(1-1-08)T

a. Collateral contact may be provided face-to-face by agency staff qualified to deliver clinical services. Face-to-face contact is defined as two (2) people meeting in person at the same time: (1-1-08)T

b. Collateral contact may be provided by telephone by agency staff qualified to deliver clinical services when it is the most expeditious an effective way to exchange information. (1-1-08)T

~~***07. Psychotherapy Limitations.*** *Psychotherapy services as set forth in Subsections 710.05.a. through 710.09.b. of this rule are limited as described under Subsection 710.10 of this rule.* *(3-30-07)*~~

08. Pharmacological Management. Pharmacological management consultations must be provided by a physician or other practitioner of the healing arts within the scope of practice defined in their license in direct contact with the participant. (3-30-07)

a. Consultation must be for the purpose of prescribing, monitoring, and/or administering medication as part of the individualized treatment plan; and (3-30-07)

b. Pharmacological management, if provided, must be part of the individualized treatment plan and frequency and duration of the treatment must be specified. (3-30-07)

09. Nursing Services. Nursing services, when physician ordered and supervised, can be part of the participant's individualized treatment plan. (3-30-07)

a. Licensed and qualified nursing personnel can supervise, monitor, and administer medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code; and (3-30-07)

b. The frequency and duration of the treatment must be specified on the participant's individualized treatment plan. (3-30-07)

10. Limits on Mental Health Clinic Services. Services provided by Mental Health Clinics are limited to twenty-six (26) services per calendar year. This is for any combination of evaluation, diagnosis and treatment services. ~~*This limitation is in addition to any and all other service limitations described in these rules.*~~ A total of twelve (12) hours is the maximum time allowed for a combination of any evaluative or diagnostic services and individualized treatment plan development provided to an eligible participant in a calendar year. ~~*(3-30-07)*~~(1-1-08)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0705

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 1, 2007.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also Title XIX and Title XXI of the Social Security Act, as amended, and the companion federal regulations.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than Wednesday, November 21, 2007.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

As of September 1, 2007, the coverage for Medicaid's Basic Plan dental services will be provided by Blue Cross of Idaho under a selective contract. As a result, the rules for dental services covered under the Basic Plan are being deleted under companion Docket No. 16-0309-0707.

For those on the Enhanced Plan, dental services will continue to be covered by Medicaid as they are currently. To assure continuity of dental service coverage for those on the Enhanced Plan, the rules for Medicaid-covered dental services are being added to this chapter, including all the dental procedure codes.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(a) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because it protects the health of and confers benefits to Medicaid participants on the Enhanced Plan.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted since this rulemaking is being done to simply to assure the continuity of dental service coverage for those on the Enhanced Plan.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Arla Farmer at (208) 364-1958.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, November 28, 2007.

DATED this 23rd day of August, 2007.

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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-19-07)

02. Scope. These rules establish the Medicaid Enhanced Plan Benefits covered under Title XIX and Title XXI. Participants who are eligible for Enhanced Plan Benefits are also eligible for benefits under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," with the exception of coverage for dental services. Dental services for the Medicaid Enhanced Plan are covered under Sections 080 through 085 of these rules. ~~(3-19-07)~~(9-1-07)T

03. Scope of Reimbursement System Audits. These rules also provide for the audit of providers' claimed costs against these rules and Medicare standards. The Department reserves the right to audit financial and other records of the provider, and, when warranted, the records of entities related to the provider. Audits consist of the following types of records: (3-19-07)

a. Cost verification of actual costs for providing goods and services; (3-19-07)

b. Evaluation of provider's compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation; (3-19-07)

c. Effectiveness of the service to achieve desired results or benefits; and (3-19-07)

d. Reimbursement rates or settlement calculated under this chapter. (3-19-07)

04. Exception to Scope for Audits and Investigations. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct." (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

004. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following document: (3-19-07)

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations internet site at http://www.access.gpo.gov/nara/cfr/cfr-table-search.html. (3-19-07)

02. CDT - 2007/2008 (Current Dental Terminology, Sixth Edition). Current Dental Terminology, Sixth Edition, is available from the American Dental Association, 211 East Chicago Ave., Chicago, IL 60601-9985, or may be ordered online at http://www.adacatalog.org. A copy is available for public review at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (9-1-07)T

02~~3~~. DSM-IV-TR. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (3-19-07)

03~~4~~. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (3-19-07)

04~~5~~. Medicare Region D Durable Medical Equipment Regional Carrier (DMERC) Supplier Manual or Its Successor. The full text of the Medicare Region D DMERC Supplier Manual Chapters IX and X, date April 2001, is available via the Internet at www.cignamedicare.com. A copy is also available at the Idaho State Supreme Court Law Library. (3-19-07)

05~~5~~6. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II CMS Publication 15-1 and 15-2), is available on the CMS internet site at http://cms.hhs.gov/manuals/pub151/PUB_15_1.asp and http://cms.hhs.gov/manuals/pub152/PUB_15_2.asp. (3-19-07)

06~~7~~7. Resource Utilization Groups (RUG) Grouper. The RUG III, version 5.12, 34 Grouper, nursing weights only, with index maximization. The RUG Grouper is available from CMS, 7500 Security Blvd., Baltimore, MD, 21244-1850. (3-19-07)

07~~8~~8. SIB-R Comprehensive Manual. Scales of Independent Behavior - Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. (3-19-07)

08~~9~~9. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.state.id.us. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

075. ENHANCED PLAN BENEFITS - COVERED SERVICES.
Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits~~.~~," with the exception of coverage for dental services. In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. ~~*(3-19-07)*~~(9-1-07)T

01. Dental Services. Dental Services are provided as described under Sections 080 through 085 of these rules. (9-1-07)T

01~~2~~2. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (3-19-07)

02~~3~~3. Enhanced Mental Health Benefits. Enhanced Mental Health services are provided under Sections 100 through 147 of these rules. (3-19-07)

03~~4~~4. Enhanced Home Health Benefits. Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (3-19-07)

04~~5~~5. Therapies. Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (3-19-07)

05~~6~~6. Long Term Care Services. The following services are provided under the Long Term Care Services. (3-30-07)

a. Nursing Facility Services as described in Sections 220 through 299 of these rules. (3-19-07)

b. Personal Care Services as described in Sections 300 through 308 of these rules. (3-30-07)

c. A & D Wavier Services as described in Sections 320 through 330 of these rules. (3-30-07)

0~~6~~7. Hospice. Hospice services as described in Sections 450 through 459 of these rules**.** (3-19-07)

0~~7~~8. Developmental Disabilities Services. (3-19-07)

a. Developmental Disability Standards as described in Sections 500 through 506 of these rules. (3-19-07)

b. Behavioral Health Prior Authorization as described in Sections 507 through 520 of these rules. (3-19-07)

c. ICF/MR as described in Sections 580 through 649 of these rules. (3-19-07)

d. Developmental Disabilities Agencies as described in Sections 700 through 719 of these rules. (3-19-07)

0~~8~~9. Service Coordination Services. Service coordination as described in 720 through 779 of these rules. (3-19-07)

***~~09~~*10. Breast and Cervical Cancer Program**. Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

076. - 0~~8~~79. (RESERVED).

080. DENTAL SERVICES - DEFINITIONS.
Dental services are provided for the relief of dental pain, prosthetic replacement, and the correcting of handicapping malocclusion. These services must be purchased from a licensed dentist or denturist. (9-1-07)T

081. DENTAL SERVICES - PARTICIPANT ELIGIBILITY.

01. Children's Coverage. Dental services for children, covered through the month of their twenty-first birthday, are listed in Sections 080 through 085 of these rules. (9-1-07)T

02. Adult Coverage. Covered dental services for Medicaid eligible persons who are past the month of their twenty-first birthday who are not eligible under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Pregnant Women (PW), Qualified Medicare Beneficiary (QMB), or under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," are listed in Subsections 082.14 and 082.15 of these rules. (9-1-07)T

03. Limitations on Orthodontics. Orthodontics are limited to participants from birth to twenty-one (21) years of age who meet the eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant. The Malocclusion Index may be found in the Appendix A of these rules. Participants already in orthodontic treatment who transfer to Idaho Medicaid must have their continuing treatment justified and authorized by the state Medicaid dental consultant. (9-1-07)T

04. Participants Eligible for Other Programs. Participants who have only Qualified Medicare Beneficiary (QMB) eligibility are not eligible for dental services. (9-1-07)T

082. DENTAL SERVICES - COVERAGE AND LIMITATIONS.

01. Covered Dental Services. Dental services are covered by Medicaid as described in Section 081 of these rules. Idaho uses the procedure codes contained in the Current Dental Terminology (CDT) handbook published by the American Dental Association. (9-1-07)T

02. Non-Covered Services. Non-covered services are procedures not recognized by the American Dental Association (ADA) or services not listed in these rules. (9-1-07)T

03. Diagnostic Dental Procedures.

TABLE 082.03 - DENTAL DIAGNOSTIC PROCEDURES

Dental Code	Description
a. General Oral Evaluations. The following evaluations are not allowed in combination of the same day:	
D0120	Periodic oral evaluation. Includes periodontal screening. One (1) periodic examination is allowed every six (6) months.
D0140	Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem. Not to be used when a participant returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.
D0150	Comprehensive oral evaluation. One (1) comprehensive examination is allowed every twelve (12) months. Six (6) months must elapse before a periodic exam can be paid.
D0160	Detailed and extensive oral evaluation. A detailed and extensive problem focused evaluation that entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. One (1) detailed and extensive oral evaluation is allowed every twelve (12) months.
D0170	Re-evaluation, limited, problem focused. Established participant, not post-operative visit.

TABLE 082.03 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	**Description**
b. Radiographs/Diagnostic Images.	
D0210	Intraoral - complete series (including bitewings). Complete series x-rays are allowed only once in a three (3) year period. A complete intraoral series consists of fourteen (14) periapicals and one (1) series of four (4) bitewings.
D0220	Intraoral periapical - first film.
D0230	Intraoral periapical - each additional film.
D0240	Intraoral occlusal film.
D0270	Bitewing - single film. Total of four (4) bitewings allowed every six (6) months.
D0272	Bitewings - two (2) films. Total of four (4) bitewings allowed every six (6) months.
D0274	Bitewings - four (4) films. Total of four (4) bitewings allowed every six (6) months.
D0277	Vertical bitewings. Seven (7) to eight (8) films. Allowed every six (6) months.
D0330	Panoramic film. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a thirty-six (36) month period. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to four (4) bitewings or periapicals are allowed in addition to a panoramic film.
D0340	Cephalometric film. Allowed once in a twelve (12) month period.
c. Test And Laboratory Examination.	
D0460	Pulp vitality tests. Includes multiple teeth and contralateral comparison(s) as indicated. Allowed once per visit per day.
D0470	Diagnostic casts.
d. Diagnostic.	
D0999	Unspecified diagnostic procedure, by report. Narrative required when prior authorizing.

(9-1-07)T

04. Dental Preventive Procedures. Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis.

TABLE 082.04 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	**Description**
a. Dental Prophylaxis.	
D1110	Prophylaxis - Adult (twelve (12) years of age and older). A prophylaxis is allowed once every six (6) months. Includes polishing procedures to remove coronal plaque, calculus, and stains.
D1120	Prophylaxis - Children/young adult (under age twelve (12)). A prophylaxis is allowed once every six (6) months.
b. Fluoride Treatments.	

TABLE 082.04 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	**Description**
D1203	Topical application of fluoride - one (1) treatment. Prophylaxis not included. Allowed once every six (6) months for participants under age twenty (21).
D1204	Topical application of fluoride - adult, twenty-one (21) years of age and over. Prophylaxis not included. Allowed once every six (6) months.
c. Other Preventive Services.	
D1351	Sealant - per tooth. Mechanically and/or chemically prepared enamel surface. Allowed for participants under twenty-one (21) years of age. Limited to once per tooth every three (3) years. Tooth designation required.
d. Space Management Therapy. Space maintainers are allowed to hold space for missing teeth for participants under age twenty-one (21). No reimbursement is allowed for removing maintainers, unless by dentist other than providing dentist. Vertical space maintainers are not covered.	
D1510	Space maintainer - fixed - unilateral. Limited up to age twenty-one (21). Only allowed once per tooth space. Tooth space designation required.
D1515	Space maintainer - fixed - bilateral. Limited up to age twenty-one (21). Only allowed once per arch. Arch designation required.
D1520	Space maintainer, removable - unilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1525	Space maintainer, removable - bilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1550	Re-cementation of space maintainer. Limited up to age twenty-one (21). Only allowed once per quadrant or arch. Quadrant or arch designation required.

(9-1-07)T

05. Restorations. (9-1-07)T

a. Posterior Restoration. (9-1-07)T

i. A one (1) surface posterior restoration is one in which the restoration involves only one (1) of the five (5) surface classifications: mesial, distal, occlusal, lingual, or facial (including buccal or labial). (9-1-07)T

ii. A two (2) surface posterior restoration is one in which the restoration extends to two (2) of the five (5) surface classifications. (9-1-07)T

iii. A three (3) surface posterior restoration is one in which the restoration extends to three (3) of the five (5) surface classification surface classifications. (9-1-07)T

iv. A four (4) or more surface posterior restoration is one in which the restoration extends to four (4) or more of the five (5) surface classifications. (9-1-07)T

b. Anterior Proximal Restoration. (9-1-07)T

i. A one (1) surface anterior proximal restoration is one in which neither the lingual nor facial margin of the restoration extends beyond the line angle. (9-1-07)T

ii. A two (2) surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle. (9-1-07)T)

iii. A three (3) surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle. (9-1-07)T

iv. A four (4) or more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved. (9-1-07)T

c. Amalgams and Resin Restoration. (9-1-07)T

i. Reimbursement for pit restoration is allowed as a one (1) surface restoration. (9-1-07)T

ii. Adhesives (bonding agents), bases, and the adjustment and/or polishing of sealant and restorations are included in the allowance for the major restoration. (9-1-07)T

iii. Liners and bases are included as part of the restoration. If pins are used, they should be reported separately. (9-1-07)T

d. Crowns. (9-1-07)T

i. When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required. (9-1-07)T

ii. Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification. (9-1-07)T

TABLE 082.05 - RESTORATIONS	
Dental Code	**Description**
e. Amalgam Restorations.	
D2140	Amalgam - one (1) surface, primary or permanent. Tooth designation required.
D2150	Amalgam - two (2) surfaces, primary or permanent. Tooth designation required.
D2160	Amalgam - three (3) surfaces, primary or permanent. Tooth designation required.
D2161	Amalgam - four (4) or more surfaces, primary or permanent. Tooth designation required.
f. Resin Restorations. Resin refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are part of the restoration. Report glass ionomers when used as restorations. If pins are used, report them separately.	

TABLE 082.05 - RESTORATIONS	
Dental Code	**Description**
D2330	Resin - one (1) surface, anterior. Tooth designation required.
D2331	Resin - two (2) surfaces, anterior. Tooth designation required.
D2332	Resin - three (3) surfaces, anterior. Tooth designation required.
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior. Tooth designation required.
D2390	Resin based composite crown, anterior, primary or permanent. Tooth designation required.
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
g. Crowns.	
D2710	Crown resin indirect. Tooth designation required. Prior authorization required.
D2721	Crown resin with predominantly base metal. Tooth designation required. Prior authorization required.
D2750	Crown, porcelain fused to high noble metal. Tooth designation required. Prior authorization required.
D2751	Crown porcelain fused too predominantly base metal. Tooth designation required. Prior authorization required.
D2752	Crown, porcelain fused to noble metal. Tooth designation required. Prior authorization required.
D2790	Crown, full cast, high noble metal. Tooth designation required. Prior authorization required.
D2791	Crown full cast predominantly base metal. Tooth designation required. Prior authorization required.
D2792	Crown, full cast noble metal. Tooth designation required. Prior authorization required.
h. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
D2930	Prefabricated stainless steel crown - primary tooth. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth. Tooth designation required.
D2932	Prefabricated resin crown. Tooth designation required.
D2940	Sedative filling. Tooth designation required. Surface is not required.
D2950	Core buildup, including any pins. Tooth designation required. Limited to two (2) pins per tooth.
D2951	Pin retention - per tooth, in addition to restoration. Tooth designation required. Limited to two (2) pins per tooth.
D2954	Prefabricated post and core in addition to crown. Tooth designation required.
D2955	Post removal. Tooth designation required.
D2980	Crown repair. Tooth designation required.
D2999	Unspecified restorative procedure, by report. Narrative and tooth designation required when prior authorizing. Requires prior authorization.

(9-1-07)T

06. Endodontics. Pulpotomies and root canal procedures cannot be paid with the same date of service for the same tooth.

TABLE 082.06 - ENDODONTICS	
Dental Code	**Description**
a. Pulp Capping.	
D3110	Pulp cap - direct (excluding final restoration). Tooth designation required.
b. Pulpotomy.	
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required. Not to be construed as the first stage of root canal therapy.
D3221	Pulpal debridement, primary & permanent teeth. For relief of acute pain not to be construed as the first stage of root canal therapy. Not allowed same day as endodontic therapy. Tooth designation required.
c. Root Canal Therapy. Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Root canal therapy (includes treatment plan, x-rays, clinical procedures and follow-up care) is for permanent teeth only. Separate charges are allowable for open and drain if the procedure is done on different days.	
D3310	Anterior (excluding final restoration). Tooth designation required.
D3320	Bicuspid (excluding final restoration). Tooth designation required.
D3330	Molar (excluding final restoration). Tooth designation required.
D3346	Retreatment of previous root canal therapy, anterior. Tooth designation required.
D3347	Retreatment of previous root canal therapy, bicuspid. Tooth designation required.
D3348	Retreatment of previous root canal therapy, molar. Tooth designation required.
d. Apicoectomy/Periradicular Services.	
D3410	Apicoectomy/Periradicular surgery-anterior surgery or root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.
D3421	Apicoectomy/Periradicular surgery-bicuspid (first root). Surgery on one root of a bicuspid does not include placement of retrograde filling material. Tooth designation required.
D3425	Apicoectomy/Periradicular surgery-Molar (first root). Does not include placement of retrograde filling material. Tooth designation required.
D3426	Apicoectomy/Periradicular surgery (each additional root). For molar surgeries when more than one root is being treated during the same procedure. Does not include retrograde filling material placement. Tooth designation required.
D3430	Retrograde filling - per root. For placement of retrograde filling material during Periradicular surgery procedures. Tooth designation required.
D3999	Unspecified restorative procedure, by report. Narrative and tooth designation required. Requires prior authorization.

(9-1-07)T

07. Periodontics.

TABLE 082.07 - PERIODONTICS	
Dental Code	**Description**
a. Surgical Services.	
D4210	Gingivectomy or gingivoplasty - four (4) or more contiguous teeth in quadrant. Quadrant designation required.
D4211	Gingivectomy or gingivoplasty - one (1) to three (3) teeth in quadrant. Quadrant designation required.
b. Non-Surgical Periodontal Services.	
D4320	Provisional splinting - intracoronal.
D4321	Provisional splinting - extracoronal.
D4341	Periodontal scaling and root planing four (4) or more contiguous teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. Allowed once in a twelve (12) month period. The removal of subgingival and/or supragingival plaque and calculus. This is a preliminary procedure and does not preclude the need for other procedures.
c. Other Periodontal Services.	
D4910	Periodontal maintenance procedures. Allowed once in a three (3) month period. This procedure is for participants who have completed periodontal treatment (surgical and/or non-surgical periodontal therapies exclusive of D4355) and includes removal of the bacterial flora from crevicular and pocket areas, scaling and polishing of the teeth, periodontal evaluation, and a review of the participant's plaque control efficiency.
D4999	Unspecified periodontal procedure. Narrative required when prior authorizing. Requires prior authorization.

(9-1-07)T

08. Prosthodontics. (9-1-07)T

a. Removable Prosthodontics. (9-1-07)T

i. The Medicaid dental program covers only one (1) set of full dentures in a five (5) year period. Full dentures placed immediately must be of structure and quality to be considered the final set. Transitional or interim treatment dentures are not covered. No additional reimbursements are allowed for denture insertions. (9-1-07)T

ii. If full dentures are inserted during a month when the participant is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the

dentures is allowed. (9-1-07)T

iii. Medicaid pays for partial dentures once every five (5) years. Partial dentures are limited to participants age twelve (12) and older. One (1) partial per arch is covered. When a partial is inserted during a month when the participant is not eligible but all other work, including laboratory work, is completed during an eligible period, the claim for the partial is allowed. (9-1-07)T

b. Removable Prosthodontics by Codes.

TABLE 082.08.b. - PROSTHODONTICS	
Dental Code	**Description**
i. Complete Dentures. This includes six (6) months of adjustments following placement.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.
ii. Partial Dentures. This includes six (6) months of care following placement. Limited to twelve (12) years and older.	
D5211	Maxillary partial denture - resin base. Includes any conventional clasps, rests, and teeth.
D5212	Mandibular partial denture - resin base. Includes any conventional clasps, rests, and teeth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
iii. Adjustments To Complete And Partial Dentures. No allowance for adjustments for six (6) months following placement. Adjustments done during this period are included in complete/partial allowance.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
iv. Repairs To Complete Dentures.	
D5510	Repair broken complete denture base. Arch designation required.
D5520	Replace missing or broken teeth - complete denture (each tooth) - six (6) tooth maximum. Tooth designation required.
v. Repairs To Partial Dentures.	
D5610	Repair resin denture base. Arch designation required.
D5620	Repair cast framework. Arch designation required.
D5630	Repair or replace broken clasp. Arch designation required.

TABLE 082.08.b. - PROSTHODONTICS	
Dental Code	**Description**
D5640	Replace broken teeth, per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture. Involves clasp or abutment tooth.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
vi. Denture Relining. Relines will not be allowed for six (6) months following placement of denture and then only once every two (2) years.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
vii. Other Removable Prosthetic Services.	
D5850	Tissue conditioning, maxillary - per denture unit.
D5851	Tissue conditioning, mandibular per denture unit.
D5899	Unspecified removable prosthetic procedure, by report. Narrative required when prior authorizing. Requires prior authorization.
D5899	Unable to deliver full or partial denture. Prior authorization required. If the participant does not complete the process for the denture; leaves the state; cannot be located; or dies; the laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

(9-1-07)T

09. Maxillo-Facial Prosthetics.

TABLE 082.09 - MAXILLO-FACIAL PROSTHETICS	
Dental Code	Description
D5931	Obturator prosthesis, surgical. Narrative required when prior authorizing. Requires prior authorization.
D5932	Obturator prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.

TABLE 082.09 - MAXILLO-FACIAL PROSTHETICS	
D5933	Obturator prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5934	Mandibular resection prosthesis with guide flange. Narrative required when prior authorizing. Requires prior authorization.
D5935	Mandibular resection prosthesis without guide flange. Narrative required when prior authorizing. Requires prior authorization.
D5936	Obturator prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.
D5951	Feeding aid. Narrative required when prior authorizing. Requires prior authorization.
D5952	Speech aid prosthesis, pediatric. Narrative required when prior authorizing. Requires prior authorization.
D5953	Speech aid prosthesis, adult. Narrative required when prior authorizing. Requires prior authorization.
D5954	Palatal augmentation prosthesis. Narrative required when prior authorizing. Requires prior authorization.
D5955	Palatal lift prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.
D5958	Palatal lift prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.
D5959	Palatal life prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5960	Speech aid prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5982	Surgical stent. Narrative required when prior authorizing. Requires prior authorization.
D5988	Surgical splint. Narrative required when prior authorizing. Requires prior authorization.
D5999	Unspecified maxillofacial prosthesis. Narrative required when prior authorizing. Requires prior authorization.

(9-1-07)T

10. Fixed Prosthodontics.

TABLE 082.10 - FIXED PROSTHODONTICS	
Dental Code	**Description**
Other Fixed Prosthetic Services.	
D6930	Re-cement fixed partial denture.
D6980	Fixed partial denture repair.
D6999	Unspecified fixed prosthodontic procedure, by report. Narrative required when prior authorizing Requires prior authorization.

(9-1-07)T

11. Oral Surgery.

TABLE 082.11 - ORAL SURGERY	
Dental Code	**Description**
a. Simple Extraction.	
D7111	Extraction, coronal remnants - deciduous tooth. Including soft-tissue retained coronal remnants.
D7140	Extraction, erupted tooth or exposed root, routine removal.
b. Surgical Extractions.	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, and closure. Tooth designation required.
D7220	Removal of impacted tooth - soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth -- partially bony. Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7240	Removal of impacted tooth - completely bony. Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications. Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Allowed only when pathology is present. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of gingiva and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.
c. Other Surgical Procedures.	
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus. Tooth designation required. Includes splinting and/or stabilization.
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons. Includes orthodontic attachments. Tooth designation required. Limited to participants under twenty-one (21) years of age.
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption. Tooth designation required. Limited to participants under twenty-one (21) years of age.
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
D7287	Cytology sample collection via mild scraping of oral mucosa.
d. Alveoloplasty.	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant. Quadrant designation is required.
e. Excision of Bone Tissue.	
D7471	Removal of lateral exostosis. Maxilla or mandible. Arch designation required.
f. Surgical Incision.	

TABLE 082.11 - ORAL SURGERY	
Dental Code	**Description**
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
g. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
h. Other Repair Procedures.	
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure. The frenum may be excised when the tongue has limited mobility; for large diastema between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.
D7970	Excision of hyperplastic tissue - per arch. Arch designation required.
D7971	Excision of pericoronal gingiva. Arch designation required.
D7999	Unspecified oral surgery, by report. Narrative required when prior authorizing. Requires prior authorization.

(9-1-07)T

12. Orthodontics.

TABLE 082.12 - ORTHODONTICS	
Dental Code	**Description**
a. Limited Orthodontics. Orthodontic treatment with a limited objective, not involving the entire dentition may be directed at the only existing problem, or one aspect of a larger problem in which a decision is made to defer or forgo more comprehensive therapy.	
D8010	Limited orthodontic treatment of primary dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8020	Limited orthodontic treatment of transitional dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8030	Limited orthodontic treatment of adolescent dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8040	Limited orthodontic treatment of adult dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
b. Comprehensive Orthodontic Treatment. The coordinated diagnosis and treatment leading to the improvement of a participant's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances, and can also include removable appliances, headgear, and maxillary expansion procedures. Must score at least eight (8) points on the State's Handicapping Malocclusion Index.	
D8070	Comprehensive orthodontic treatment of transition dentition. Models, panorexes, and treatment plan are required when prior authorizing. Requires prior authorization.

TABLE 082.12 - ORTHODONTICS	
Dental Code	**Description**
D8080	Comprehensive orthodontic treatment of adolescent dentition, up to sixteen (16) years of age. Models, panorexes, and treatment plan are required when prior authorizing. Requires prior authorization.
D8090	Comprehensive orthodontic treatment of adult dentition. Justification required. Models, panoramic film, and treatment plan are required when prior authorizing. Requires prior authorization.
c. Minor Treatment to Control Harmful Habits.	
D8210	Removable appliance therapy. Removable indicates participant can remove; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.
D8220	Fixed appliance therapy. Fixed indicates participant cannot remove appliance; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.
d. Other Services.	
D8670	Adjustments monthly. When utilizing treatment codes D8070, D8080 or D8090 a maximum of twenty-four (24) adjustments over two (2) years will be allowed (twelve (12) per year) when prior authorizing. When utilizing treatment codes D8210 or D8220, two (2) adjustments will be allowed per treatment when prior authorizing. Requires prior authorization.
D8680	Orthodontic retention, removal of appliances, construction and placement of retainer(s). Replacement appliances are not covered. Includes both upper and lower retainer if applicable.
D8691	Repair of orthodontic appliance. Limited to one (1) occurrence.
D8999	Unspecified orthodontics. Narrative required when prior authorizing. No payment for lost or destroyed appliances. Requires prior authorization.

(9-1-07)T

13. Adjunctive General Services.

TABLE 082.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
a. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain - minor procedure (open and drain abscess, etc.). Open and drain is included in the fee for root canal when performed during the same sitting. Tooth or quadrant designation required.
b. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes. Not included as general anesthesia are tranquilization; nitrous oxide; or enteral or parenteral administration of analgesic, sedative, tranquilizing, or dissociative agents.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.

TABLE 082.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes. Provider certification required.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes. Provider certification required.
c. Professional Consultation.	
D9310	Consultation. Provided by dentist or physician whose opinion or advice regarding the evaluation, management and/or treatment of a specific problem or condition is requested by another dentist or physician. The written or verbal request for a consult must be documented in the participant's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant's medical record and communicated to the requesting dentist or physician. A dental consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
d. Professional Visits.	
D9410	House/Extended Care Facility Calls. Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per participant. To be used when participant's health restrictions require treatment at the house/extended care facility. If procedures are done in the hospital, use procedure code D9420.
D9420	Hospital Calls. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited once per day per participant. Not covered for routine preoperative and postoperative. If procedures are done in other than hospital or surgery center use procedure code D9410 found in this table.
D9430	Office visit for observation (during regularly scheduled hours). No other services performed.
D9440	Office visit after regularly scheduled hours.
e. Miscellaneous Service.	
D9920	Behavior Management. May be reported in addition to treatment provided when the participant is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. Notation and justification must be written in the participant's record identifying the specific behavior problem and the technique used to manage it. Allowed once per participant per day.
D9930	Treatment of complication (post-surgical) - unusual circumstances.
D9940	Occlusal guards - removable dental appliances which are designed to minimize the effects of bruxism (tooth grinding) and other occlusal factors. No payment for replacement of lost or destroyed appliances.
D9951	Occlusal adjustment, limited. May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a per-visit basis. Allowed once every twelve (12) months.

TABLE 082.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
D9952	Occlusal adjustment, complete. Occlusal adjustment may require several appointments of varying length and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be used for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma, when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma. Justification required when prior authorizing. Requires prior authorization.
D9999	Unspecified adjunctive procedure, by report. Narrative required when prior authorizing. Requires prior authorization.

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14. Dental Codes For Adult Services. The following dental codes are covered for adults after the month of their twenty-first birthday.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
a. Dental Diagnostic Procedures. The definitions for these codes are in Subsection 082.03 of theses rules.	
i. General Oral Evaluations.	
D0120	Periodic oral evaluation.
D0140	Limited oral evaluation.
D0150	Comprehensive oral evaluation.
ii. Radiographs/Diagnostic Images.	
D0210	Intraoral - complete series.
D0220	Intraoral periapical - first film.
D0230	Intraoral periapical - each additional film.
D0270	Bitewing - single film.
D0272	Bitewings - two (2) films.
D0274	Bitewings - four (4) films.
D0277	Vertical bitewings - seven (7) to eight (8) films.
D0330	Panoramic film.
b. Dental Preventive Procedures. The definitions for these codes are in Subsection 082.04 of theses rules.	
i. Dental Prophylaxis.	
D1110	Prophylaxis - adult.
ii. Fluoride Treatments.	

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D1204	Topical application of fluoride - prophylaxis not included - adult.
c. Dental Restorative Procedures. The definitions for these codes are in Subsection 082.05 of theses rules.	
i. Amalgam Restorations.	
D2140	Amalgam - one (1) surface, primary or permanent.
D2150	Amalgam - two (2) surfaces, primary or permanent.
D2160	Amalgam - three (3) surfaces, primary or permanent.
D2161	Amalgam - four (4) or more surfaces, primary or permanent.
ii. Resin Restorations.	
D2330	Resin - one (1) surface, anterior.
D2331	Resin - two (2) surfaces, anterior.
D2332	Resin - three (3) surfaces, anterior.
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior.
D2390	Resin based composite crown, anterior, primary or permanent.
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
iii. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth.
D2940	Sedative filling.
d. Endodontics. The definitions for these codes are in Subsection 082.06 of theses rules.	
D3220	Therapeutic pulpotomy.
D3221	Pulpal debridement, permanent teeth.
e. Periodontics. The definitions for these codes are in Subsection 082.07 of theses rules.	
i. Non-Surgical Periodontal Service.	
D4341	Periodontal scaling and root planing - four (4) or more contiguous teeth (per quadrant).
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant.
D4355	Full mouth debridement.
ii. Other Periodontal Services.	
D4910	Periodontal maintenance procedures.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
f. **Prosthodontics**. The definitions for these codes are in Subsection 082.08.b. of theses rules.	
i. Complete Dentures.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.
ii. Partial Dentures.	
D5211	Maxillary partial denture - resin base.
D5212	Mandibular partial denture - resin base.
iii. Adjustments to Dentures.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
iv. Repairs to Complete Dentures.	
D5510	Repair broken complete denture base.
D5520	Replace missing or broken teeth - complete denture, each tooth.
v. Repairs to Partial Dentures.	
D5610	Repair resin denture base.
D5620	Repair cast framework.
D5630	Repair or replace broken clasp.
D5640	Replace broken teeth, per tooth.
D5650	Add tooth to existing partial denture.
D5660	Add clasp to existing partial denture.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
vi. Denture Relining.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
g. Oral Surgery. The definitions for these codes are in Subsection 082.11 of theses rules.	
i. Extractions.	
D7111	Extraction, coronal remnants - deciduous tooth.
D7140	Extraction, erupted tooth or exposed root, routine removal.
ii. Surgical Extractions	
D7210	Surgical removal of erupted tooth.
D7220	Removal of impacted tooth - soft tissue.
D7230	Removal of impacted tooth -- partially bony.
D7240	Removal of impacted tooth - completely bony.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250	Surgical removal of residual tooth roots.
iii. Other Surgical Procedures.	
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
iv. Surgical Incision.	
D7510	Incision and drainage of abscess - including periodontal origins.
v. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
vi. Other Repair Procedures.	
D7970	Excision of hyperplastic tissue.
D7971	Excision of pericoronal gingiva.
h. Adjunctive General Services. The definitions for these codes are in Subsection 082.13 of theses rules.	
i. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain.
ii. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
iii. Professional Consultation.	
D9310	Consultation requested by other dentist or physician.
iv. Professional Visits.	
D9410	House, institutional, or extended care facility calls.house/extended care facility.
D9420	Hospital calls.
D9440	Office visit after regularly scheduled hours.
D9930	Treatment of complication (post-surgical) - unusual circumstances.

(9-1-07)T

15. Denturist Procedure Codes. (9-1-07)T

a. The following codes are valid denturist procedure codes:

TABLE 082.15.a. - DENTURIST PROCEDURE CODES	
Dental Code	**Description**
D5110	Complete denture, upper
D5120	Complete denture, lower
D5130	Immediate denture, upper
D5140	Immediate denture, lower
D5410	Adjust complete denture, upper
D5411	Adjust complete denture, lower
D5421	Adjust partial denture, upper
D5422	Adjust partial denture, lower
D5510	Repair broken complete denture base; arch designation required.
D5520	Replace missing or broken teeth, complete denture (each tooth); six (6) teeth maximum. Tooth designation required.
D5610	Repair resin saddle or base; arch designation required.
D5620	Repair cast framework; arch designation required.
D5630	Repair or replace broken clasp; arch designation required.
D5640	Replace broken teeth per tooth; tooth designation required.
D5650	Add tooth to existing partial denture; tooth designation required.
D5660	Add clasp to existing partial denture; not requiring the altering of oral tissue or natural teeth. Tooth designation required.
D5730	Reline complete upper denture (chairside)

TABLE 082.15.a. - DENTURIST PROCEDURE CODES	
Dental Code	**Description**
D5731	Reline complete lower denture (chairside)
D5740	Reline upper partial denture (chairside)
D5741	Reline lower partial denture (chairside)
D5750	Reline complete upper denture (laboratory)
D5751	Reline complete lower denture (laboratory)
D5760	Reline upper partial denture (laboratory)
D5761	Reline lower partial denture (laboratory)
D5899	Unable to deliver full denture. Prior authorization required. If the participant does not complete the process for the denture, leaves the state, cannot be located or dies, laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

(9-1-07)T

b. Medicaid allows complete and immediate denture construction once every five (5) years. Denture reline is allowed once every two (2) years. Complete and partial denture adjustment is considered part of the initial denture construction service for the first six (6) months. (9-1-07)T

083. DENTAL SERVICES - PROCEDURAL REQUIREMENTS.

01. Dental Prior Authorization. All procedures that require prior authorization must be approved by the Medicaid dental consultant prior to the service being rendered. Prior authorization requires a written submission including diagnostics. Verbal authorizations will not be given. Retroactive authorization will be given only in an emergency situation or as the result of retroactive eligibility. Prior authorization of Medicaid dental procedures does not guarantee payment. (9-1-07)T

02. Denturist Prior Authorization. Prior authorization is not required for the dentist procedures except for dental code D5899 found in Subsection 082.15.a. of these rules. (9-1-07)T

03. Crowns. (9-1-07)T

a. When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required. (9-1-07)T

b. Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification. (9-1-07)T

084. DENTAL SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
All dental services must be documented in the participant's record to include: procedure, surface, and tooth number, if applicable. This record must be maintained for a period of six (6) years. (9-1-07)T

085. DENTAL SERVICES - PROVIDER REIMBURSEMENT.
Medicaid reimburses dentists and denturists for procedures on a fee-for-service basis. Usual and customary charges are paid up to the Medicaid maximum allowance. Dentists may make arrangements for private payment with families for services not covered by Medicaid. If the provider accepts any Medicaid payment for a covered service, the Medicaid payment must be accepted as payment in full for the service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (9-1-07)T

086. -- 089. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

624. ICF/MR - CAPPED COST.
Beginning October 1, 1996, this cost area includes all allowable costs except those specifically identified as property costs in Section 623 of these rules and exempt costs or excluded costs in Section 627 or 628 of these rules. This Section defines items and procedures to be followed in determining allowable and exempt costs and provides the procedures for extracting cost data from historical cost reports, applying a cost forecasting market basket to project cost forward, procedures to be followed to project costs forward, and procedures for computing the median of the range of costs and the ICF/MR cap. (3-19-07)

01. Costs Subject to the Cap. Items subject to the cap include all allowable costs except property costs identified in Section 623 of these rules and exempt costs or excluded costs identified in Section 627 or 628 of these rules. Property costs related to a home office are administrative costs, will not be reported as property costs, and are subject to the cap. (3-19-07)

02. Per Diem Costs. Costs to be included in this category will be divided by the total participant days for the facility for the cost reporting period to arrive at allowable per diem costs. If costs for services provided some or all non-Medicaid residents are not included in the total costs submitted, the provider must determine the costs and combine them with the submitted costs in order that a total per diem cost for that facility can be determined both for both the purposes of determining the ICF/MR cap and of computing final reimbursement. (3-19-07)

03. Cost Data to Determine the Cap. Cost data to be used to determine the cap for ICF/MR facilities will be taken from each provider's most recent final cost report available sixty (60) days before the beginning of the period for which the cap is being set. Cost reports are final when the final audit report is issued, or earlier if the Department informs the facility the report is final for rate setting purposes. The selected final cost report will be used to establish the facility's prospective reimbursement rate. However, the final cost reports covering a period of less than twelve (12) months will be included in the data for determining the cap at the option of the Department. (3-19-07)

04. Projection. Per diem allowable costs will be inflated forward using a cost forecasting market basket and forecasting indices according to the same table as used for free

standing facilities. (3-19-07)

a. The projection method used in Section 624 of these rules to set the cap will also be used to set non property portions of the prospective rate which are not subject to the cap. (3-19-07)

b. Forecasting indices as developed by Data Resources, Incorporated, will be used unless they are unavailable. In such case, indices supplied by some other nationally recognized forecaster will be used. (3-19-07)

05. Costs Which Can be Paid Directly by the Department to Non ICF/MR Providers. Costs which can be paid directly by the Department to non ICF/MR providers are excluded from the ICF/MR prospective rates and ICF/MR cap: (3-19-07)

a. Direct physician care costs. Physicians who provide these services must bill the Medicaid program directly using their own provider numbers. (3-19-07)

b. Costs of services covered under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) portion of the Medicaid Program. ~~*These services are enumerated in*~~ Items such as eyeglasses and hearing aids are covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits~~,~~." ~~*and include such items and services as eyeglasses, hearing aids, and d*~~Dental services provided to ~~*Medicaid*~~ EPSDT participants who are under the age of twenty-one (21) and who reside in an ICF/MR, are covered under Sections 080 through 085 of these rules. The cost of these services is not includable as a part of ICF/MR costs. Reimbursement can be made to a professional providing these services through his billing the Medicaid Program on his own provider number. ~~*(3-19-07)*~~(9-1-07)T

c. Costs of services covered by other parts of the Medicaid Program. Examples of these items include legend drugs and ambulance transportation. These items must be billed to the Medicaid Program directly by the provider using his own provider number. (3-19-07)

06. Cost Projection. Allowable per diem costs will be projected forward from the midpoint of the Base Period to the midpoint of the Target Period. "Base Period" is defined as the last available final cost report period. "Target Period" is defined as the effective period of the prospective rate. Procedures for inflating these costs are as follows: (3-19-07)

a. The percentage change for each cost category in the market basket will be computed from the beginning to the end of the Base Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward allowable per diem costs for each cost category from the midpoint to the end of the Base Period. (3-19-07)

b. The percentage change for each cost category in the market basket will be computed for the period from the end of the Base Period to the beginning of the Target Period. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Subsection 624.06.a. of these rules, from the end of the Base Period to the beginning of the Target Period. (3-19-07)

c. The percentage change for each cost category in the market basket will be

computed for the beginning to the end of the Target Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward the allowable per diem costs as determined in Subsection 624.06.b. of these rules from the beginning to the midpoint of the Target Period. (3-19-07)

07. Cost Ranking. Prior to October 1st of each year the Director will determine the that percent above the median which will assure aggregate payments to ICF/MR providers will approximate but not exceed amounts that would be incurred using Medicare cost principles of reimbursement. That percentage will apply to caps and rates set after September 30th of each year. Projected per diem costs as determined in this section and subject to the cap will be ranked from the highest to the lowest. The cap will be set at a percent of the bed-weighted median for each rate period. The initial cap will be set as of October 1, 1996. (3-19-07)

a. The median of the range will be computed based on the available data points being considered as the total population of data points. (3-19-07)

b. The cap for each ICF/MR facility with a fiscal year beginning October 1, 1996, will be computed prior to the beginning of that year. For those facilities with a fiscal year ending on a date other than September 30th, the first cap will be computed for the period beginning October 1, 1996, and ending on the fiscal year end date. (3-19-07)

c. Facilities with cost reports that transcend the period from October 1, 1996, through September 30, 1997, will be retrospectively settled using the previous reimbursement system for the period of the report up to September 30, 1996. There will not be a retrospective settlement on the portion of these cost reports attributed to October 1, 1996 through the end of the cost report period unless provisions of Section 626 of these rules apply. (3-19-07)

d. Cost reports for periods beginning on or after October 1, 1996, will not be subject to retrospective settlement except as required by other provisions of this chapter. (3-19-07)

e. A new cap and rate will be set on an annual basis for each facility the first of July every year. (3-19-07)

f. The cap and prospective rate will be determined and set on an annual basis for each facility July first of every year and will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical or clerical errors, these errors will be corrected and the cap will be adjusted using the corrected figures. (3-19-07)

g. Payment of costs subject to the cap will be limited to the cap unless the Department determines the exclusions found in Section 628 of these rules apply. (3-19-07)

h. A facility which commences to offer participant care services as an ICF/MR on or after October 1, 1996, will be subject to retrospective settlement until the first prospective rate is set. Such facility will be subject to the ICF/MR cap as determined in this chapter. The first prospective rate for this provider will be set by the Department based on quarterly cost statements and final cost reports submitted for periods following the first three (3) months of operation. This first prospective rate may be set after the beginning of the second fiscal year of the provider. For

the second year the provider will be paid a rate to be settled retrospectively unless both the Department and the provider agree to a prospective rate or rates covering that fiscal period..
(3-19-07)

APPENDIX A

IDAHO MEDICAID HANDICAPPING MALOCCLUSION INDEX

OVERBITE:	**MEASUREMENT/POINTS:**	**SCORE:**
Lower incisors: striking lingual of uppers at incisal	1/3 = 0	
Striking lingual of uppers at middle	1/3 = 1	
Striking lingual of uppers at gingival	1/3 = 2	
OPENBITE: (millimeters) *a,b		
Less than……	2 mm = 0	
	2-4 mm = 1	
	4+ mm = 2	
OVERJET: (millimeters) *a		
Upper……	2-4 mm = 0	
Measure horizontally parallel to occlusal plane.	5-9 mm = 1	
	9+ mm = 2	
Lower…….	0-1 mm = 0	
	2 mm = 1	
	3+ mm = 2	
POSTERIOR X-BITE: (teeth) *b		
Number of teeth in x-bite:	0-2 = 0	
	3 = 1	
	4 = 2	
TOOTH DISPLACEMENT: (teeth) *c, d, e		
Number of teeth rotated 45 degrees or displaced 2mm from normal position in arch.	0-2 = 0 3-6 = 1 7+ = 2	
BUCCAL SEGMENT RELATION-SHIP:		
One side distal or mesial ½ cusp	= 0	

OVERBITE:	**MEASUREMENT/POINTS:**	**SCORE:**
Both sides distal or mesial or one side full cusp	= 1	
Both sides full cusp distal or mesial	= 2	

TOTAL SCORE:

Scoring Definitions:

Impacted or blocked cuspids are scored 1 open bite and 1 over jet for two teeth. Score 2 for open bite and 2 for over jet for 4 blocked cuspids.

a) Cross bites are scored for the teeth in cross bite, not the teeth in the opposing arch.

b) Missing teeth count as 1, if the space is still present.

c) Do not score teeth that are not fully erupted.

d) Displaced teeth are based on where they are in their respective arch line, not their relationship with the opposing arch.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0706

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2007.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; Title XIX and Title XXI of the Social Security Act, as amended, and the companion federal regulations; also, Sections 39-5602 and 39-5603, Idaho Code as amended by HB 167 (2007).

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Tuesday, November 20, 2007 - 6:00 p.m.
Department of Health and Welfare
Medicaid Central Office
3232 Elder Street
Conference Room D-East
Boise, Idaho

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

House Bill 167 (2007) was passed to clarify the difference between a personal assistance services agency and a fiscal intermediary agency. Fiscal intermediary services were originally developed to allow consumers to direct the care provided by their personal assistance "employees" (e.g., those providing them directly with personal care services). However, the way the original legislation was written, agencies or organizations providing fiscal intermediary services were forced to become personal assistance services agencies before they could be fiscal intermediary agencies. This created a conflict for the agencies, consumers, and the Department of Health and Welfare. The changes to statute approved under HB 167 addressed these issues.

The proposed rule changes align the rules related to personal assistance services and fiscal intermediary services provided under the Home and Community Based Services Waiver for the Aged and Disabled (A&D) with the changes made to Idaho Code by HB 167 (2007) that went into effect July 1, 2007.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code,

the Governor has found that temporary adoption of the rule is appropriate in order to comply with the amendments to governing law under HB 167 (2007).

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rulemaking was done into order to bring the rules into alignment with the amendments to statute made under House Bill 167 (2007). NOTE: HB167, and hence these rules, are the direct result of discussions between the Department and the State Independent Living Council (SILC).

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Susan Scheuerer at (208) 287-1156.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, November 28, 2007.

DATED this 22nd day of September, 2007.

Sherri Kovach, Program Supervisor
DHW - Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-6558 fax
kovachs@dhw.idaho.gov e-mail

THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

010. DEFINITIONS A THROUGH D.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Accrual Basis. An accounting system based on the principle that revenues are recorded when they are earned; expenses are recorded in the period incurred. (3-19-07)

02 Active Treatment. Active treatment is the continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided in accordance with a treatment plan developed by an interdisciplinary team and monitored by a qualified mental retardation professional (QMRP) directed toward: the acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or the prevention or deceleration of regression or loss of current functional status. (3-19-07)

03. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-19-07)

04. Allowable Cost. Costs that are reimbursable, and sufficiently documented to meet the requirements of audit. (3-19-07)

05. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-19-07)

06. Appraisal. The method of determining the value of property as determined by an American Institute of Real Estate Appraiser (MAI) appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. (3-19-07)

07. Assets. Economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

08. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically-oriented tasks dealing with the functional needs of the participants and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADL). These services may include~~*, but are not limited to,*~~ personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or the participant. Services are based on the person's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. ~~*(3-19-07)*~~(7-1-07)T

09. Audit. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider’s financial statements and records with Medicaid law, regulations, and rules. (3-19-07)

10. Auditor. The individual or entity designated by the Department to conduct the audit of a provider’s records. (3-19-07)

11. Audit Reports. (3-19-07)

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider’s review and comments. (3-19-07)

b. Final Audit Report. A final written report containing the results, findings, and

recommendations, if any, from the audit of the provider, as approved by the Department. (3-19-07)

c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. (3-19-07)

12. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (3-19-07)

13. Bed-Weighted Median. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (3-19-07)

14. Capitalize. The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (3-19-07)

15. Case Mix Adjustment Factor. The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average nursing facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average nursing facility-wide acuity is the average of the indexes that correspond to the cost reporting period. (3-19-07)

16. Case Mix Index (CMI). A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition, that projects the amount of relative resources needed to provide care to the resident. (3-19-07)

a. Nursing Facility Wide Case Mix Index. The average of the entire nursing facility's case mix indexes identified at each picture date during the cost reporting period. If case mix indexes are not available for applicable quarters due to lack of data, case mix indexes from available quarters will be used. (3-19-07)

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG classification. Medicaid or non-Medicaid status is based upon information contained in the MDS databases. To the extent that Medicaid identifiers are found to be incorrect, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (3-19-07)

c. State-Wide Average Case Mix Index. The simple average of all nursing facilities "facility wide" case mix indexes used in establishing the reimbursement limitation July 1st of each year. The state-wide case mix index will be calculated annually during each July 1st rate setting. (3-19-07)

17. Certified Family Home. A home certified by the Department to provide care to one (1) or two (2)adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence. (3-19-07)

l8. Chain Organization. A proprietorship, partnership, or corporation that leases, manages, or owns two (2) or more facilities that are separately licensed. (3-19-07)

19. Claim. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-19-07)

20. Clinical Nurse Specialist. A licensed professional nurse who meets all the applicable requirements to practice as clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

21. Collateral Contact. Contact made with a parent, guardian, or other individual having a primary relationship to the patient by an appropriately qualified treatment professional. The contact must be ordered by a physician, contained in the treatment plan, directed at the medical treatment of the patient, and documented in the progress notes or continuous service record. (3-19-07)

22. Common Ownership. An individual, individuals, or other entities who have equity or ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. (3-19-07)

23. Compensation. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (3-19-07)

24. Control. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. (3-19-07)

25. Cost Center. A "collection point" for expenses incurred in the rendering of services, supplies, or materials that are related or so considered for cost-accounting purposes. (3-19-07)

26. Cost Component. The portion of the nursing facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a nursing facility's rate is established annually at July 1st of each year. (3-19-07)

27. Cost Reimbursement System. A method of fiscal administration of Title XIX and Title XXI which compensates the provider on the basis of expenses incurred. (3-19-07)

28. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-19-07)

29. Cost Statements. An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (3-19-07)

30. Costs Related to Patient Care. All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include, but are not limited to, costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs. (3-19-07)

31. Costs Not Related to Patient Care. Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are nonallowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are nonallowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (3-19-07)

32. Customary Charges. Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM, Chapter 3, Sections 310 and 312. (3-19-07)

33. Day Treatment Services. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the Intermediate Care Facility for the Mentally Retarded (ICF/MR). However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (3-19-07)

34. Department. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. (3-19-07)

35. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (3-19-07)

36. Developmental Disability (DD). A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before the age of twenty-two (22) years of age; and (3-19-07)

a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, which requires similar treatment or services or is attributable to dyslexia resulting from such impairments; (3-19-07)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (3-19-07)

37. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (3-19-07)

a. Direct nursing salaries that include the salaries of professional nurses (RN), licensed professional nurses, certified nurse's aides, and unit clerks; (3-19-07)

b. Routine nursing supplies; (3-19-07)

c. Nursing administration; (3-19-07)

d. Direct portion of Medicaid related ancillary services; (3-19-07)

e. Social services; (3-19-07)

f. Raw food; (3-19-07)

g. Employee benefits associated with the direct salaries: and (3-19-07)

h. Medical waste disposal, for rates with effective dates beginning July 1, 2005. (3-19-07)

38. Director. The Director of the Department of Health and Welfare or his designee. (3-19-07)

39. Durable Medical Equipment (DME). Equipment other than prosthetics or orthotics which can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a medical assistance participant. (3-19-07)

011. DEFINITIONS E THROUGH K.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Educational Services. Services which are provided in buildings, rooms or areas designated or used as a school or as educational facilities; which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and which are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related services**;** and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (3-19-07)

02. Eligibility Rules. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged,

Blind and Disabled (AABD)." (3-19-07)

03. Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (3-19-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-19-07)

b. Serious impairment to bodily functions. (3-19-07)

c. Serious dysfunction of any bodily organ or part. (3-19-07)

04. Enhanced Plan. The medical assistance benefits included under this chapter of rules. (3-19-07)

05. EPSDT. Early and Periodic Screening Diagnosis and Treatment. (3-19-07)

06. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

07. Facility. Facility refers to a hospital, nursing facility, or an intermediate care facility for persons with mental retardation. (3-19-07)

a. "Free-standing Nursing Facility" means a nursing facility that is not owned, managed, or operated by, nor is otherwise a part of a licensed hospital. (3-19-07)

b. "Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)" means an entity as defined in Subsection 011.29 in this rule. (3-19-07)

c. "Nursing Facility (NF)" means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients. (3-19-07)

d. Skilled Nursing Facility" means a nursing facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and federally certified as a "Nursing Facility" under Title XVIII. (3-19-07)

e. "Urban Hospital-Based Nursing Facilities" means hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (3-19-07)

08. Fiscal Intermediary Agency. An entity that provides services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing, training, and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (7-1-07)T

0~~8~~9. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. (3-19-07)

10~~9~~. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-19-07)

1~~0~~1. Funded Depreciation. Amounts deposited or held which represent recognized depreciation. (3-19-07)

1~~1~~2. Generally Accepted Accounting Principles (GAAP). A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. (3-19-07)

1~~2~~3. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is a nonallowable, nonreimbursable expense. (3-19-07)

1~~3~~4. Healthy Connections. The primary care case management model of managed care under Idaho Medicaid. (3-19-07)

1~~4~~5. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (3-19-07)

1~~5~~6. ICF/MR Living Unit. The physical structure that an ICF/MR uses to house patients. (3-19-07)

1~~6~~7. Improvements. Improvements to assets which increase their utility or alter their use. (3-19-07)

1~~7~~8. Indirect Care Costs. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (3-19-07)

a. Activities; (3-19-07)

b. Administrative and general care costs; (3-19-07)

c. Central service and supplies; (3-19-07)

d. Dietary (non-"raw food" costs); (3-19-07)

e. Employee benefits associated with the indirect salaries; (3-19-07)

f. Housekeeping; (3-19-07)

g. Laundry and linen; (3-19-07)

h. Medical records; (3-19-07)

i. Other costs not included in direct care costs, or costs exempt from cost limits; and (3-19-07)

j. Plant operations and maintenance (excluding utilities). (3-19-07)

1~~8~~9. Inflation Adjustment. The cost used in establishing a nursing facility's prospective reimbursement rate is indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (3-19-07)

~~19~~20. Inflation Factor. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. The national index is used when there is no state or regional index. (3-19-07)

2~~0~~1. In-State Care. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (3-19-07)

2~~1~~2. Inspection of Care Team (IOCT). An interdisciplinary team which provides inspection of care in intermediate care facilities for the mentally retarded approved by the Department as providers of care for eligible medical assistance participants. Such a team is composed of: (3-19-07)

a. At least one (1) registered nurse; and (3-19-07)

b. One (1) qualified mental retardation professional; and when required, one (1) of the following: (3-19-07)

i. A consultant physician; or (3-19-07)

ii. A consultant social worker; or (3-19-07)

iii. When appropriate, other health and human services personnel responsible to the Department as employees or consultants. (3-19-07)

2~~2~~3. Instrumental Activities of Daily Living (IADL). Those activities performed in

supporting the activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (3-19-07)

2~~3~~4. Interest. The cost incurred for the use of borrowed funds. (3-19-07)

2~~4~~5. Interest on Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are reported under property costs. (3-19-07)

2~~5~~6. Interest on Working Capital. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are reported under administrative costs. (3-19-07)

2~~6~~7. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/MR facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (+1%) at the date the loan is made. (3-19-07)

2~~7~~8. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (3-19-07)

2~~8~~9. Intermediary. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare. (3-19-07)

~~29~~30. Intermediate Care Facility for Persons with Mental Retardation (ICF/MR). An entity licensed as an ICF/MR and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-19-07)

3~~0~~1. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. Premiums related to keyman insurance are not allowable. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

013. DEFINITIONS P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Patient Day. For a nursing facility or an ICF/MR, a calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care will be deemed to exist. (3-19-07)

02. Participant. A person eligible for and enrolled in the Idaho Medical Assistance

Program. (3-19-07)

03. Patient. The person undergoing treatment or receiving services from a provider. (3-19-07)

04. Personal Assistance Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, and is the employer of record ~~*and in fact, and may provide fiscal intermediary services*~~ as well as the actual employer. ~~*(3-19-07)*~~(7-1-07)T

05. Personal Assistance Services (PAS). Services that include both attendant care for participants under an HCBS waiver and personal care services for participants under the Medicaid State Plan. PAS means services that involve personal and medically-oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADLs). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. ~~*(3-19-07)*~~(7-1-07)T

06. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a state or United States territory. (3-19-07)

07. Physician's Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants." (3-19-07)

08. Picture Date. A point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility's rate for the next quarter. (3-19-07)

09. Plan of Care. A written description of medical, remedial, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (3-19-07)

10. Private Rate. Rate most frequently charged to private patients for a service or item. (3-19-07)

11. PRM. The Provider Reimbursement Manual. (3-19-07)

12. Property. The homestead and all personal and real property in which the participant has a legal interest. (3-19-07)

13. Property Costs. Property costs are the total of allowable interest expense, plus

depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish which components are an integral part of property costs. (3-19-07)

14. Property Rental Rate. A rate paid per Medicaid patient day to free-standing nursing facilities and ICF/MRs in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/MR facilities. (3-19-07)

15. Provider. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and has entered into a written provider agreement with the Department in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

16. Provider Agreement. An written agreement between the provider and the Department, in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

17. Provider Reimbursement Manual (PRM). The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, which are incorporated by reference in Section 004 of these rules. (3-19-07)

18. Psychologist, Licensed. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-19-07)

19. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (3-19-07)

20. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-19-07)

21. Raw Food. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (3-19-07)

22. Reasonable Property Insurance. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year cannot be considered reasonable. (3-19-07)

23. Recreational Therapy (Services). Those activities or services that are generally

perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, training for Special Olympics, and special day parties (birthday, Christmas, etc.). (3-19-07)

24. Regional Medicaid Services (RMS). Regional offices of the Division of Medicaid. (3-19-07)

25. Regional Nurse Reviewer (RNR). A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX and Title XXI long term care for the Department. (3-19-07)

26. Registered Nurse - R.N. Which in the state of Idaho is known as a Licensed Professional Nurse and who meets all the applicable requirements to practice as a licensed professional nurse under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01 "Rules of the Idaho Board of Nursing." (3-19-07)

27. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes services, facilities, or supplies for the provider (3-19-07)

28. Related to Provider. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (3-19-07)

29. Residential Care or Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. In this chapter, Residential Care or Assisted Living Facilities are referred to as "facility." Distinct segments of a facility may be licensed separately, provided each segment functions independently and meets all applicable rules. (3-19-07)

30. Resource Utilization Groups (RUG). A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. The RUG Grouper is used for the purposes of rate setting and determining nursing facility level of care. (4-1-07)T

31. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (3-19-07)

32. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (3-19-07)

~~***33. Speech/Language Pathology and Audiology Services**. Diagnostic, screening, preventative, or corrective services provided by a licensed speech pathologist or audiologist, for which a patient is referred by a physician or other practitioner of the healing arts within the scope of his or her practice under state law. Speech, hearing and language services do not include equipment needed by the patient such as communication devices or environmental controls.*~~

~~*(3-19-07)*~~

3~~4~~3. **State Plan**. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-19-07)

3~~5~~4. **Supervision**. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-19-07)

3~~6~~5. **Title XVIII**. Title XVIII of the Social Security Act, known as Medicare, for the aged, blind, and disabled administered by the federal government. (3-19-07)

3~~7~~6. **Title XIX**. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-19-07)

3~~8~~7. **Title XXI**. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-19-07)

3~~9~~8. **Third Party**. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant of medical assistance. (3-19-07)

***~~40~~*39.** **Transportation**. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-19-07)

4~~1~~0. **Uniform Assessment**. A set of standardized criteria to assess functional and cognitive abilities. (3-19-07)

4~~2~~1. **Uniform Assessment Instrument (UAI)**. A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities as described in IDAPA 16.03.23 “Rules Governing Uniform Assessments of State-Funded Clients.” (3-19-07)

4~~3~~2. **Utilities**. All expenses for heat, electricity, water and sewer. (3-19-07)

4~~4~~3. **Utilization Control (UC)**. A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants or participants to Title XIX and Title XXI benefits in a nursing facility. (3-19-07)

4~~5~~4. **Utilization Control Team (UCT)**. A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the nursing facilities approved by the Department as providers of care for eligible medical assistance participants. (3-19-07)

4~~6~~5. **Vocational Services**. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be

able to participate in a sheltered workshop or in the general work force within one (1) year. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

306. PERSONAL ASSISTANCE AGENCY (PAA) - QUALIFICATIONS AND DUTIES.

01. Provider Agreement Required. A Personal Assistance Agency is an organization that has signed the Medicaid Provider General Agreement and the Additional Terms-Personal Assistance Agencies, Aged and Disabled Waiver Provider Agreement with the Department. The PAA agrees to comply with all conditions within the agreements. A Personal Assistance Agency may also provide fiscal intermediary services ~~*as defined*~~ in accordance with Section 329 of these rules. Each Personal Assistance Agency must direct, control, and monitor the work of each of its personal assistants. ~~*(3-19-07)*~~(7-1-07)T

02. Responsibilities of a Personal Assistance Agency. A Personal Assistance Agency must be capable of and is responsible for all of the following, no matter how the PAA is organized or the form of the business entity it has chosen: (3-19-07)

a. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal assistants and the assurance that all providers are qualified to provide quality service; (3-19-07)

b. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; (3-19-07)

c. Maintenance of liability insurance coverage. Termination of either worker's compensation or professional liability insurance by the provider is cause for termination of the provider's provider agreement; (3-19-07)

d. Provision of a licensed professional nurse (RN) or, where applicable, a QMRP supervisor to develop and complete plans of care and provide ongoing supervision of a participant's care; (3-19-07)

e. Assignment of qualified personal assistants to eligible participants after consultation with and approval by the participants; (3-19-07)

f. Assuring that all personal assistants meet the qualifications in Subsection 305.01 of these rules; (3-19-07)

g. Billing Medicaid for services approved and authorized by the RMS; (3-19-07)

h. Collecting any participant contribution due; (7-1-07)T

i. Conducting, at least annually, participant satisfaction or quality control reviews

which are available to the Department and the general public; and (7-1-07)T

~~*h*~~**i.** Making referrals for PCS-eligible participants for service coordination as described in Sections 720 through 779 of these rules when a need for the service is identified. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

321. AGED OR DISABLED WAIVER SERVICES - DEFINITIONS.
The following definitions apply to Sections 320 through 330 of these rules: (3-19-07)

01. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department to assess functional and cognitive abilities. (3-19-07)

~~***02. Fiscal Intermediary Services**. Services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered.* *(3-19-07)*~~

0~~3~~2. **Individual Service Plan**. A document which outlines all services including, but not limited to, personal assistance services and instrumental activities of daily living (IADL), required to maintain the individual in his home and community. The plan is initially developed by the RMS or its contractor for services provided under the Home and Community-Based Services Waiver. This plan must be approved by the RMS and all Medicaid reimbursable services must be contained in the plan. (3-19-07)

0~~4~~3. **Personal Assistance Agency or Agency**. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for the care given, and provides payroll, including all required withholding for federal and state tax purposes, and benefits for care providers working for them. They also bill Medicaid for services provided by employees, and collect participant contribution. (3-19-07)

0~~5~~4. **Employer of Record**. An entity which bills for services, withholds required taxes, and conducts other administrative activities for a waiver program participant. Such an entity is also called a personal assistance agency functioning as a fiscal intermediary agency.
~~*(3-19-07)*~~(7-1-07)T

0~~6~~5. **Employer of Fact**. A participant or representative of a participant who hires, fires, and directs the services delivered by a waiver program provider. This individual may be a family member. (3-19-07)

0~~7~~6. **Participant**. An aged or disabled individual who requires and receives services under the Home and Community-based Waiver program. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

329. AGED OR DISABLED WAIVER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a~~n~~ personal assistance agency or fiscal intermediary agency is still not available. ~~(3-30-07)~~(7-1-07)T

02. ~~Personal Assistance Agency That Provides~~ Fiscal Intermediary Services. An ~~personal assistance~~ agency that ~~focuses on fostering participant independence and personal control of services delivered~~ has responsibility for the following~~. The core tasks are~~:
~~(3-19-07)~~(7-1-07)T

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-19-07)

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (3-19-07)

c. To bill the Medicaid program for services approved and authorized by the Department; (3-19-07)

d. To collect any participant participation due; (3-19-07)

e. To pay personal assistants and other waiver service providers for service; (3-19-07)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-19-07)

g. To ~~offer a full range of services and perform all services contained in a written agreement between the participant and the provider~~ assure that personal assistants providing services meet the standards and qualifications under in this rule; ~~(3-19-07)~~(7-1-07)T

h. To maintain liability insurance coverage; (7-1-07)T

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; (7-1-07)T

~~***h***~~**j.** To ~~*M*~~make referrals for service coordination for a PCS-eligible participant ~~*for service coordination*~~ when a need for such services is identified; and ~~*(3-19-07)*~~(7-1-07)T

~~***i***~~**k.** To ~~*O*~~obtain such criminal background checks and health screens on new and existing employees of record and fact as required. ~~*(3-19-07)*~~(7-1-07)T

03. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's approved Aged and Disabled waiver as approved by CMS. (3-19-07)

a. A waiver provider can not be a relative of any participant to whom the provider is supplying services. (3-19-07)

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (3-19-07)

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks," including: (1-1-07)T

i. Companion services; (1-1-07)T

ii. Chore services; and (1-1-07)T

iii. Respite care services. (1-1-07)T

04. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (3-19-07)

05. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (3-19-07)

06. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (3-19-07)

a. A master's degree in a behavioral science; (3-19-07)

b. Be licensed in accordance with state law and regulations; or (3-19-07)

c. A bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems. (1-1-07)T

d. Psychiatric consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

07. Service Coordination. Service coordinators and service coordination agencies must meet the requirements specified in Section 729 of these rules unless specifically modified by another section of these rules. (3-19-07)

08. Consultation Services. Services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (3-19-07)

09. Adult Residential Care Providers. Adult Residential Care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," and IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (1-1-07)T

10. Home Delivered Meals. Providers must be a public agency or private business and must be capable of: (3-19-07)

a. Supervising the direct service; (3-19-07)

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (3-19-07)

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (3-19-07)

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (3-19-07)

e. Being inspected and licensed as a food establishment by the district health department. (3-19-07)

11. Personal Emergency Response Systems. Providers must demonstrate that the devices installed in waiver participant's homes meet Federal Communications Standards, Underwriter's Laboratory Standards, or equivalent standards. (3-19-07)

12. Adult Day Care. Facilities that provide adult day care must be maintained in safe and sanitary manner. (3-30-07)

a. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served. (3-19-07)

b. Providers who accept participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served. (3-30-07)

c. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks History and Background Checks." (1-1-07)T

13. Assistive Technology. All items must meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need. (3-19-07)

14. Assisted Transportation Services. See Subsection 329.03 of this rule for provider qualifications. (3-19-07)

15. Attendant Care. See Subsection 329.03 of this rule for provider qualifications. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

16. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

17. Home Modifications. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (3-19-07)

18. Residential Habilitation Provider Qualifications. Residential habilitation services must be provided by an agency that is capable of supervising the direct services provided. Individuals who provide residential habilitation services in their own home must be certified by the Department as a certified family home and must be affiliated with a residential habilitation agency. The residential habilitation agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide residential habilitation services in the home of the participant (supported living), must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: (3-30-07)

a. Direct service staff must meet the following minimum qualifications: (3-30-07)

i. Be at least eighteen (18) years of age; (3-30-07)

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of care; (3-30-07)

iii. Have current CPR and First Aid certifications; (3-30-07)

iv. Be free from communicable diseases; (3-30-07)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-30-07)

vi. Residential habilitation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" (1-1-07)T

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator who has demonstrated experience in writing skill training programs, if no agency is available in their geographic area as outlined in Subsection 329.18.c. of this rule. (3-30-07)

c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services by a program coordinator who has a valid service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. (3-30-07)

d. Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-30-07)

i. Purpose and philosophy of services; (3-30-07)

ii. Service rules; (3-30-07)

iii. Policies and procedures; (3-30-07)

iv. Proper conduct in relating to waiver participants; (3-30-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-30-07)

vi. Participant rights; (3-30-07)

vii. Methods of supervising participants; (3-30-07)

viii. Working with individuals with traumatic brain injuries; and (3-30-07)

ix. Training specific to the needs of the participant. (3-30-07)

e. Additional training requirements must be completed within six (6) months of employment or affiliation with the residential habilitation agency and include at a minimum: (3-30-07)

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-30-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-30-07)

iii. Feeding; (3-30-07)

iv. Communication; (3-30-07)

v. Mobility; (3-30-07)

vi. Activities of daily living; (3-30-07)

vii. Body mechanics and lifting techniques; (3-30-07)

viii. Housekeeping techniques; and (3-30-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-30-07)

f. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed; and (3-30-07)

g. When residential habilitation services are provided in the provider's home, the provider must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes." Non-compliance with the certification process is cause for termination of the provider agreement or contract. (3-30-07)

19. Day Rehabilitation Provider Qualifications. Providers of day rehabilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day rehabilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

20. Supported Employment Service Providers. Supported employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State-approved provider, and have taken a traumatic brain injury training course approved by the Department. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."

(1-1-07)T

21. Behavior Consultation or Crisis Management Service Providers. Behavior consultation or crisis management providers must meet the following: (3-30-07)

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; (3-30-07)

b. Be a licensed pharmacist; or (3-30-07)

c. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-30-07)

d. Take a traumatic brain injury training course approved by the Department. (3-30-07)

e. Emergency back-up providers must also meet the minimum provider qualifications under residential habilitation services. (3-30-07)

f. Behavior consultation or crisis management service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0707

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2008.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also Title XIX and Title XXI of the Social Security Act, as amended, and the companion federal regulations.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than December 19, 2007.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Psychotherapy sessions with family or caregivers, without the participant being present, are often medically necessary for appropriate treatment of a psychiatric participant who is paranoid, agitated or physically aggressive. These rules have been amended to allow for family psychotherapy sessions without a participant being present. The other mental health services have been revised to reflect the appropriate use of these services to best collaborate and coordinate care regarding the participant's treatment. These types of interventions will help decrease the participant's distress, manage behavioral problems, improve caregiver safety, and avoid crises that require emergency interventions such as hospitalization. Evidence based practice has shown that the length of treatment is shortened when family therapy is one of the treatment services provided. This rule change includes updates to citations.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because it confers benefits to Medicaid participants on the Enhanced Plan.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

This rulemaking is anticipated to be cost neutral and will have no fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, formal negotiated rulemaking was not conducted but informal negotiations have been held with the Mental Health Providers' Association and other stakeholders.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Diane Miller at (208) 364-1844.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before December 26, 2007.

DATED this 22nd day of October, 2007.

Sherri Kovach, Program Supervisor
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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

123. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - DESCRIPTIONS.
The goal of PSR services is to aid participants in work, school, family, community, or other issues related to their mental illness. It is also to aid them in obtaining developmentally appropriate skills for living independently and to prevent movement to a more restrictive living situation. All services provided must be clinically appropriate in content, service location and duration and based on measurable and behaviorally specific and achievable objectives. PSR consists of the following services described in Subsections 123.01 through 123.08 of this rule.

(3-19-07)(1-1-08)T

01. Pharmacological Management. Pharmacological management services must be provided in accordance with the individualized treatment plan. Pharmacological management, alone, may be provided if the plan indicates that this service is necessary and sufficient to prevent relapse or hospitalization and that functional deficits are either manageable by the participant or absent but expected to return if pharmacological management is not provided. The telephoning of prescriptions to the pharmacy is not a billable service. Medication prescription must be done by a licensed physician or other practitioner of the healing arts within the scope of practice defined in

their license in visual contact with the participant. (3-19-07)

02. Individual Psychosocial Rehabilitation (PSR). Individual psychosocial rehabilitation must be provided in accordance with the objectives specified in the individualized treatment plan. Individual PSR is a service provided to an individual participant on a one-to-one basis. Individual PSR is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications, in accordance with Section 131 of these rules. Individual PSR includes one (1) or more of the following: (3-19-07)

a. Assistance in gaining and utilizing skills necessary to undertake school, employment, or independence. This includes helping the participant learn personal hygiene and grooming, selecting and acquiring appropriate clothing, time management and other skills related to participant's psychosocial circumstances; (3-19-07)

b. Ongoing on-site assessment, evaluation, and feedback sessions, including one hundred twenty (120) day reviews, to identify symptoms or behaviors related to the participant's mental illness and to develop interventions with the participant and his employer or teacher; (3-19-07)

c. Individual interventions in social skill training to improve communication skills and facilitate appropriate interpersonal behavior directly related to the participant's mental illness; (3-19-07)

d. Problem solving, support, and supervision related to activities of daily living to assist participants in gaining and utilizing skills such as personal hygiene, household tasks, use of transportation, and money management; (3-19-07)

e. Assisting the participant with receiving necessary services when he has difficulty or is unable to obtain them. (3-19-07)

i. This assistance may be given by accompanying him to Medicaid-reimbursable appointments. For reimbursement purposes, the PSR agency staff person must be present during the appointment and deliver a PSR service during the appointment. Travel time and time waiting to meet with the Medicaid provider are not reimbursable; however, reimbursement is available for the delivery of prior authorized PSR services occurring during these times. (3-19-07)

ii. To be eligible for this service, the participant must have a functional impairment that affects his ability to communicate accurately due to a mental illness and be unable to report symptoms to a licensed practitioner, as identified in Subsection 131.01 of these rules, or be unable to understand the practitioner's instructions. The impairment must be identified in the assessment. The individualized treatment plan must identify how the impairment is to be resolved and include objectives toward independence in this area. For children, this service is not intended to replace the parent's responsibility in advocating for or attending appointments for their child; (3-19-07)

f. Medication education may be provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating the participant about the role and effects of medications in treating symptoms of mental illness and symptom management. (3-19-07)

g. Development of coping skills and symptom management to identify the symptoms of mental illness that are barriers to successful community integration and crisis prevention. (3-19-07)

h. May assist participant with "self" administration of medications by verbal prompts according to the direction of the prescribing physician. Verbal prompts must be delivered face-to-face and an assessment of the participant's functioning must be completed and documented. In cases where verbal prompts by phone are justified, they must be specifically prior authorized. (3-19-07)

03. Group Psychosocial Rehabilitation (PSR). Group PSR must be provided in accordance with the objectives specified in the individualized treatment plan. Group PSR is a service provided to two (2) or more individuals concurrently. Group PSR is reimbursable if provided by an agency with a current provider agreement and the agency staff person delivering the service meets the qualifications in accordance with Section 131 of these rules. This service includes one (1) or more of the following: (3-19-07)

a. Medication education groups provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating participants about the role and effects of medications in treating symptoms of mental illness and symptom management. These groups must not be used solely for the purpose of group prescription writing; (3-19-07)

b. Employment or school-related groups to focus on symptom management on the job or in school, symptom reduction, and education about appropriate job or school-related behaviors; (3-19-07)

c. Communication and interpersonal skills groups, the goals of which are to improve communication skills and facilitate appropriate interpersonal behavior; (3-19-07)

d. Symptom management groups to identify mental illness symptoms which are barriers to successful community integration, crisis prevention, problem identification and resolution, coping skills, developing support systems and planning interventions with teachers, employers, family members and other support persons; and (3-19-07)

e. Activities of daily living groups which help participants learn skills related to personal hygiene, grooming, household tasks, use of transportation, socialization, and money management. (3-19-07)

04. Crisis Intervention Service. Crisis support ~~*that*~~ includes intervention for a participant in crisis situations to ensure his health and safety or to prevent his hospitalization or incarceration. Crisis intervention service is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications under Section 131 of these rules. A crisis may be precipitated by loss of housing, employment or reduction of income, risk of incarceration, risk of physical harm, family altercation or other emergencies. PSR agency staff may deliver direct services within the scope of these rules or link the participant to community resources to resolve the crisis or both. Crisis support may be

provided prior to or after the completion of the assessment and service plan. Service is reimbursable if there is documentation that supports the need for the service and the individualized treatment is either authorized the next business day following the beginning of the crisis or prior authorized in anticipation of the need for crisis support. Crisis hours are authorized on a per incident basis. ~~*(3-19-07)*~~(1-1-08)T

a. Crisis Support in a Community. Limitations to reimbursement in this place of service are described in Subsection 124 of these rules. (3-19-07)

b. Crisis Support in an Emergency Department. (3-19-07)

i. A service provided in a hospital emergency department as an adjunct to the medical evaluation completed by the emergency department physician. This evaluation may include a psychiatric assessment. (3-19-07)

ii. The goal of this service is to assist in the identification of the least restrictive setting appropriate to the needs of the participant. (3-19-07)

05. Collateral Contact. Collateral contact, as defined in Section 010 of these rules, is covered by Medicaid if it is included on the individualized treatment plan and it is necessary to gather and exchange information ~~*with individuals having a primary relationship to*~~, provide interpretation or explanation of results of psychiatric evaluations, medical examinations and procedures, other accumulated data to family or other responsible persons, or advise them how to assist the participant. ~~*(3-19-07)*~~(1-1-08)T

a. Collateral contact may be provided face-to-face by agency staff qualified to deliver services. ~~*When*~~ Face-to-face contact is defined as two (2) ~~*persons*~~ people meeting in person at the same time; or ~~*(3-19-07)*~~(1-1-08)T

b. Collateral contact may be provided by telephone~~.~~ by agency staff qualified to deliver services, ~~*W*~~when ~~*it*~~ this is the most expeditious and effective way to exchange information~~*; and*~~. ~~*(3-19-07)*~~(1-1-08)T

~~***c.*** *Collateral contact parent group. When two (2) or more parents whose children are under the age of eighteen (18), and have similar serious emotional disturbances, meet to share information and learn about their children's needs.* *(3-19-07)*~~

06. Nursing Service. A service performed by licensed and qualified nursing personnel within the limits of the Nurse Practice Act, Section 54-1402, Idaho Code. This may include supervision, monitoring, and administration of medications. (3-19-07)

07. Psychotherapy. Individual, group, and family psychotherapy must be prior authorized and provided in accordance with the objectives specified in the written individualized treatment plan, as described in Section 114 of these rules. Staff qualified to deliver psychotherapy and qualified supervisors of psychotherapy are identified in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 707 through 718. ~~*Family psychotherapy must include the participant and at least one (1) family member and must be delivered in accordance with the goals of treatment as specified in the written individualized treatment plan.* *(3-19-07)*~~(1-1-08)T

08. Occupational Therapy. Occupational therapy services must be prior authorized by the Department, based on the results of an occupational therapy evaluation completed by a licensed Occupational Therapist in accordance with Subsections 131.1~~2~~1 and 140.08 of these rules. ~~*(3-19-07)*~~(1-1-08)T

124. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - COVERAGE AND LIMITATIONS.
The following service limitations apply to PSR services, unless otherwise authorized by the Department in each region. (3-19-07)

01. Assessment. Any combination of evaluations or diagnostic services is limited to a maximum of six (6) hours annually. (3-19-07)

02. Individualized Treatment Plan. Two (2) hours per year per participant per provider agency are available for treatment plan development. (3-19-07)

03. Psychotherapy. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually. (3-19-07)

04. Crisis Intervention Service. A maximum of twenty (20) hours of crisis support in a community may be reimbursed per crisis during any consecutive five (5) day period. Authorization must follow procedure described above at Subsection 123.0~~6~~4 of these rules. ~~*(3-19-07)*~~(1-1-08)T

05. Psychosocial Rehabilitation. Any combination of PSR services excluding crisis hours are not to exceed twenty (20) hours per week and must be prior authorized by the Department. Services in excess of twenty (20) hours require additional review and prior authorization. (3-19-07)

06. Place of Service. PSR services are to be home and community-based. (3-19-07)

a. PSR services must be provided to the participant in his home and community whenever possible. Any other location, including a provider's office or clinic, may be used if the specific place of service is stated in the individualized treatment plan and is prior authorized. (3-19-07)

b. PSR services may be provided to a participant living in a residential or assisted living facility if the PSR services are determined by the Department to be appropriate, desired by the resident, and are not the responsibility of the facility or another agency under the Negotiated Service Agreement for residential or assisted living facilities. (3-19-07)

c. Prior to delivering any services in a school-based setting, the PSR agency must have a contract with the school or the Infant Toddler program. The PSR agency must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 “Medicaid Basic Plan Benefits,” Sections 850 through 856. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

128. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - RESPONSIBILITIES OF THE DEPARTMENT.
The Department will administer the provider agreement for the provision of PSR services and is responsible for the following tasks: (3-19-07)

01. Credentialing. The Department is responsible for ensuring Medicaid PSR agencies meet credentialing requirements described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 712. (3-19-07)

02. Individualized Treatment Plan Requirements. Individualized treatment plans must include the following: (3-19-07)

a. Required Documentation. The required documentation for each individualized treatment plan includes: (3-19-07)

i. Participant demographic information; (3-19-07)

ii. A comprehensive assessment as provided in S~~*ubs*~~ection ~~*123.01*~~ 113 of these rules; ~~*(3-19-07)*~~(1-1-08)T

iii. A written individualized treatment plan as provided in Section ~~*126*~~ 114 of these rules; ~~*(3-19-07)*~~(1-1-08)T

iv. Adult treatment plans require a mental health client profile; and (3-19-07)

v. Children's individualized treatment plans also require the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). (3-19-07)

b. Receipt of Required Documentation. Reimbursement for services will be authorized from the date the individualized treatment plan and other required documentation are received by the Department. For the annual update, all required documentation must be received by the Department before the expiration date of the current assessment and plan. In order for a prior authorization to remain valid throughout the treatment plan year, documentation of the one hundred twenty (120) day reviews must comply with Subsection 136.05 of these rules. (3-19-07)

c. Hours and Type of Service. The Department must authorize the number of hours and type of services which could be reasonably expected to lead to achievement of the individualized treatment plan objectives. (3-19-07)

d. Authorization Time Period. Service authorizations are limited to a twelve (12)

month period and must be reviewed and updated at least annually. (3-19-07)

03. Notice of Decision. At the point the Department makes a decision that a participant is ineligible for PSR services, a notice of decision citing the reason(s) the participant is ineligible for PSR services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian. (3-19-07)

04. Increases in Individualized Treatment Plan Hours or Change in Service Type. When the Department is notified, in writing, by the provider of recommended increases in hours or change in type of service provided, the Department must review the request and either approve or deny the request within ten (10) working days of receipt. A clear rationale for the increase in hours or change in service type must be included with the request. (3-19-07)

05. Changes to Individualized Treatment Plan Objectives or Tasks. When a provider believes that an individualized treatment plan needs to be revised without increasing hours or changing type of service, the provider should amend the individualized treatment plan at the time of the next one hundred twenty-day (120) review or when substantial changes in the participant's mental status or circumstances require immediate changes in the plan objectives. The amended individualized treatment plan must be retained in the participant’s record and submitted to the Department upon request. (3-19-07)

06. Service System. The Department is responsible for the development, maintenance and coordination of regional, comprehensive and integrated service systems. (3-19-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.14 - RULES AND MINIMUM STANDARDS FOR HOSPITALS IN IDAHO

DOCKET NO. 16-0314-0801

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2008.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section 39-1307, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than January 16, 2008.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The Department is adding a new section of rules for the minimum design, construction requirements, standards of care, and services for free standing emergency departments.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Rules are needed to establish criteria for hospitals operating an emergency department located other than on the hospital campus. This type of facility is called a "Free Standing Emergency Department." One of these facilities has been constructed in Idaho and others are planned. New rules are needed to ensure these facilities will be regulated in order to protect the health, safety, and welfare of the public.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, informal negotiated rulemaking was conducted. Representatives from the Department met on several occasions with the Idaho Hospital Association and the following hospitals: St. Alphonsus, St. Luke's and Mercy

Medical Center.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Debby Ransom, Bureau Chief, Facility Standards, at (208) 334-6626.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before January 23, 2008.

DATED this 12th day of October, 2007.

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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

371. -- 37~~9~~3. (RESERVED).

374. FREESTANDING EMERGENCY DEPARTMENT (FSED) - DEFINITION.
A freestanding emergency department (FSED) means a facility that provides emergency services twenty-four (24) hours per day, seven (7) days per week on an outpatient basis, is physically separate from a hospital, and meets the staffing and service requirements of Section 376 of these rules. A FSED is located within thirty-five (35) miles of the hospital that owns or controls it. An FSED is owned by a hospital with a dedicated emergency department that also meets the staffing and service requirements found in Section 376 of these rules. (1-1-08)T

375. FREESTANDING EMERGENCY DEPARTMENT (FSED) - STANDARDS.

01. Capability of Receiving Ground Ambulance Patients. An FSED must be capable of receiving patients transported via ground ambulance within the protocols established by a licensed Emergency Medical Services (EMS) Agency Medical Director. Provisions must be made to communicate any reduction or increase in the capability of the FSED to receive specific levels of patients to the local EMS director. (1-1-08)T

02. Transfer to Inpatient Hospital. An FSED must transfer each patient requiring inpatient hospital services as soon as a bed is available. (1-1-08)T

03. Extension of the Main Hospital. An FSED as an extension of the main hospital must comply with all applicable rules of IDAPA 16.03.14, "Rules and Minimum Standards for Hospitals in Idaho," and Section 39-1307, Idaho Code (1-1-08)T

04. Availability of Resources and Staffing for Main Hospital and FSED. Resources and staff available at the main hospital are likewise available to individuals seeking care at the FSED within the capability of the hospital. (1-1-08)T

05. Prohibited Transfers. Transferring a patient to a different provider type for surgery, with the intent of returning the patient to the FSED or main hospital for recovery, is prohibited. (1-1-08)T

06. Written Transfer Agreements. The hospital which owns and operates the FSED must have written transfer agreements with one (1) or more hospitals which provide the basis for effective working arrangements in which inpatient hospital care or other hospital departments are promptly available to patients when needed. (1-1-08)T

07. FSED Accreditation. Each hospital granted deemed status by the Centers for Medicare/Medicaid Services as a result of accreditation must ensure the FSED is included under the same accreditation. (1-1-08)T

376. FREESTANDING EMERGENCY DEPARTMENT (FSED) - STAFFING AND SERVICES.

The FSED must be integrated into the main hospital. This integration must be defined in the hospital's policies and procedures, and practices. Additional requirements are as follows: (1-1-08)T

01. Staffing. An FSED must be staffed twenty-four (24) hours per day, seven (7) days per week with: (1-1-08)T

a. A board certified physician, or board eligible emergency department physician, approved by the governing board as described under Section 200, "Governing Body and Administration," and the medical staff as described under Section 250, "Medical Staff," of these rules; (1-1-08)T

b. A qualified licensed professional nurse certified in Advanced Cardiac Life Support and Pediatric Advanced Life Support; and (1-1-08)T

c. Additional medical, nursing, and other personnel necessary to meet the needs of patients. (1-1-08)T

02. An FSED Must Provide or Arrange for: (1-1-08)T

a. At least one (1) ambulance licensed to the Critical Care Transport level by the EMS Bureau in accordance with: Title 56, Chapter 10, Idaho Code,; IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services Physician Commission"; and IDAPA 16.02.03 "Rules Governing Emergency Medical Services." If the ambulance service is not provided directly by the FSED or main hospital, a contract must be in place including a provision that requires a maximum response time of thirty (30) minutes to the FSED. (1-1-08)T

b. A communications system that is fully integrated with the main hospital and that is capable of two (2) way radio communications with local EMS agencies in accordance with

IDAPA 16.02.03, "Rules Governing Emergency Medical Services." (1-1-08)T

03. Nursing Service. Nursing service at the FSED is a nursing unit as described under Subsection 002.31 of these rules. (1-1-08)T

04. Dietary Service. The FSED must provide dietary services consistent with the needs of each patient. (1-1-08)T

05. Laboratory Service. Basic laboratory service necessary for routine tests, as described under Subsection 350.01 of these rules, must be maintained at the FSED; and(1-1-08)T

a. The FSED must be able to perform emergency (stat) laboratory tests on-site necessary to meet the needs of patients served. (1-1-08)T

b. Laboratory services must be available twenty-four (24) hours per day, seven (7) days per week; and (1-1-08)T

c. Facilities for the procurement, proper storage, and transfusion of blood and blood products must be readily available at the FSED. (1-1-08)T

06. Radiology Service. The FSED must maintain and provide radiology services sufficient to perform and interpret the radiological examinations necessary for the diagnosis and treatment of patients twenty-four (24) hours per day, seven (7) days per week. (1-1-08)T

07. Pharmacy Service. Pharmacy services must be available at the FSED as follows: (1-1-08)T

a. The FSED must provide a pharmacy or drug and medicine service for the care and treatment of patients, consistent with the size and scope of the FSED; and (1-1-08)T

b. A pharmacist must be available on the premises, or on call, at all times. (1-1-08)T

377. NOTIFICATION REQUIREMENTS TO LICENSED EMERGENCY MEDICAL SERVICES (EMS) AGENCIES.

01. Required Notifications to Licensed EMS Agencies. (1-1-08)T

a. On an annual basis, the FSED must send written notice containing the information described in Section 377.01.c of this rule, to all area EMS services and EMS services' medical directors, licensed by the Department's EMS Bureau, that transport to the facility, (1-1-08)T

b. Within three (3) business days of any change in capability, the FSED must send written notice containing the information described in Section 377.01.c of this rule, to all area EMS services and EMS services' medical directors, licensed by the Department's EMS Bureau, that may transport to the facility. (1-1-08)T

c. The written notice must include the following information: (1-1-08)T

i. A list of capabilities that are not available at the FSED but are available at the main hospital emergency department; (1-1-08)T

ii. A description of the preferred and alternate means by which an ambulance service must make a notification to the FSED that it intends to transport to the FSED. (1-1-08)T

d. The EMS Bureau will identify and provide, upon request from the FSED, the names and mailing addresses of all EMS services and medical directors that must receive notification. (1-1-08)T

02. Emergency Medical Services Physical Requirements. (1-1-08)T

a. Ambulance bays must be located close to the emergency suite and the designated treatment rooms holding patients requiring transfer to a hospital for treatment after stabilization. (1-1-08)T

b. If the FSED exists greater than thirty (30) road miles from the main hospital it must include a helicopter landing area inspected and approved for EMS helicopter landing by the Federal Aviation Administration (FAA). (1-1-08)T

c. Where appropriate, features such as garages, landing pads, approaches, lighting, and fencing required to meet state and local codes, rules, and statutes that govern the placement, safety features, and elements required to accommodate helicopter(s) and ambulance(s), must be provided on the campus of the freestanding emergency department. (1-1-08)T

378. FREESTANDING EMERGENCY DEPARTMENT (FSED) - PLANT, EQUIPMENT & PHYSICAL ENVIRONMENT.

01. Building Construction Standards. General requirements for construction of an FSED are as follows: (1-1-08)T

a. All new construction of an FSED must comply with any and all state and local building, fire, electrical, plumbing, zoning, heating, or other applicable codes adopted by the jurisdiction in which the FSED is located and which are in effect when construction is begun. Where a conflict in code requirements occurs, both requirements must be met, or at the discretion of the licensing agency, the most restrictive will apply. (1-1-08)T

b. The FSED must be structurally sound and must be maintained and equipped to assure the safety of patients, employees, and the public. (1-1-08)T

c. On the premise of an FSED where natural or man-made hazards are present, suitable fences, guards, and railings must be provided to protect patients, employees, and the public. (1-1-08)T

d. Minimum construction standards must be in accordance with the following standards incorporated by reference: (1-1-08)T

i. The 2006 Edition of National Fire Protection Association (NFPA) 101, the Life

Safety Code, Chapter 18, New Health Care Occupancies, and the applicable provisions of chapters 1 through 11, as published by the NFPA. The NFPA documents referenced in these regulations are available from the National Fire Protection Association, 11 Tracy Drive, Avon, MA 02322-9908; 1-800-344-3555; and online at http://www.nfpa.org, and; (1-1-08)T

ii. The 2006 Edition of the American Institute of Architects (AIA) Guidelines for Design and Construction of Health Care Facilities applicable to a Freestanding Emergency Department and General Hospital. The AIA documents referenced in these regulations are available from the American Institute of Architects, 1735 New York Avenue N.W., Washington, D.C. 20006; 1-800-242-3837; and online at http://www.aia.org. (1-1-08)T

e. The FSED must provide a Type 1 Essential Electrical System (generator and transfer switch) in accordance with NFPA 99, 2005 Edition. (1-1-08)T

f. The FSED must provide a Level 1 Medical Gas and Vacuum System (piped gas system) in accordance with NFPA 99, 2005 Edition. (1-1-08)T

02. Plans, Specifications, and Inspections. Plans, specifications, and inspections of any new facility construction or any addition, conversion, or remodeling of an existing structure are governed by the following: (1-1-08)T

a. Plans for new construction, additions, conversions, and remodels must be prepared by or executed under the supervision of an architect or engineer licensed in the state of Idaho. This requirement may be waived by the Department in connection with minor alterations provided the alterations comply with all construction requirements. (1-1-08)T

b. Prior to commencing work pertaining to construction of a new building, any addition or structural changes to existing facilities, or conversion of existing buildings to be used as an FSED, plans and specifications must be submitted to, and approved by, the Department. (1-1-08)T

c. Preliminary plans must be submitted and must include at least the following: (1-1-08)T

i. A functional program description as defined in 2006 Edition of AIA Guidelines for Design and Construction of Health Care Facilities; (1-1-08)T

ii. The assignment of all spaces, size of areas and rooms, and indicate in dashed outline the fixed equipment; (1-1-08)T

iii. Drawings of each floor including, but not limited to, the basement, approach or site plan, roads, parking areas, and sidewalks; (1-1-08)T

iv. The total floor area and number of beds; (1-1-08)T

v. Outline specifications describing the general construction, including interior finishes, acoustical materials, and HVAC; (1-1-08)T

vi. The plans must be drawn to scale of sufficient size to clearly present the proposed design, but not less than a scale of one-eighth (1/8) inch to one (1) foot; (1-1-08)T

vii. Before commencement of construction, working drawings must be developed in close cooperation and with approval of the Department and other appropriate agencies; (1-1-08)T

viii. The drawings and specifications must be well prepared and of accurate dimensions and must include all necessary explanatory notes, schedules, and legends. They must be stamped with the architect's or engineer's seal; and (1-1-08)T

ix. The drawings must be complete and adequate for contract purposes. (1-1-08)T

d. Prior to occupancy, the construction must be inspected and approved by the Department. The Department must be notified at least four (4) weeks prior to completion in order to schedule a timely final inspection. (1-1-08)T

e. Buildings used as a FSED must meet all the requirements of local, state, and national codes concerning fire and life safety that are applicable to hospitals. (1-1-08)T

03. Electrical Safety. (1-1-08)T

a. A preventative maintenance program must ensure an electrically safe environment within the FSED. Written policies and procedures must be established and implemented to ensure compliance with NFPA 99 Health Care Facilities, 2005 Edition. (1-1-08)T

b. Specific restrictions on the use of extension cords and adapters are: extension cords must be used in emergency situations only, be of the grounded type, and have wire gauge compatible to the piece of equipment being used; and (1-1-08)T

c. Prohibition of the use of personal electrical equipment by patients and employees. Specific items may be allowed if the hospital adopts formal policies for defining and inspecting them. (1-1-08)T

04. Smoking. Because smoking has been acknowledged to be a fire hazard, a continuous effort must be made to reduce its presence in all health care facilities. Written policy governing smoking must be conspicuously posted and made known to all freestanding emergency department personnel, patients, and the public. The policy must include provisions for compliance with Title 39, Chapter 55, Idaho Code "Clean Indoor Air" and Section 18.7 of NFPA 101, 2006 Edition. (1-1-08)T

05. Emergency Plans for Protection and Evacuation of Patients. (1-1-08)T

a. The FSED must develop a prearranged written plan for employee response for protection of patients and for orderly evacuation and relocation of occupants in case of an emergency in accordance with Section 18.7 of the Life Safety Code, 2006 Edition. (1-1-08)T

b. Fire drills must be planned by key personnel and conducted on an unannounced basis. Fire drills must be held as required by Section 18.7 of the Life Safety Code, 2006 Edition.

(1-1-08)T

06. Report of Fire. A separate report on each fire incident occurring within the FSED must be submitted to the Department within thirty (30) days of the occurrence. The reporting form, "Facility Fire Incident Report" is provided by the Department to secure specific data concerning date, origin, extent of damage, method of extinguishment, and injuries, if any. (1-1-08)T

09. Maintenance of Equipment. The FSED must establish routine test, check, and maintenance procedures for alarm systems, extinguishment systems, and all essential electrical systems. Frequency of testing, checks, and maintenance must be in accordance with applicable National Fire Protection Association Standards referenced in Chapter 2 of the 2006 "Life Safety Code" or as adopted by the Idaho State Fire Marshal. (1-1-08)T

10. Disaster Plans. (1-1-08)T

a. The FSED must have written plans for the care of casualties from both external and internal disasters. (1-1-08)T

b. The plans must be developed with the assistance of the local emergency planning committee and all appropriate community resources. (1-1-08)T

c. The plan must be reviewed and revised at least annually. (1-1-08)T

d. The plan must be a part of the overall community emergency response plan. (1-1-08)T

e. As part of the disaster and mass casualty program, a plan for the emergency supply of water must be available. This plan must include at least written contracts with any outside firms, a listing of procedures to be followed, the amounts of water needed by different departments, the means of dispensing water within the facility, and procedures for sanitizing in the case of contamination. Plans utilizing existing piping are recommended. (1-1-08)T

11. External Disaster Plan. (1-1-08)T

a. The hospital and FSED must conduct a hazard vulnerability analysis and develop a plan for external disasters for the geographic area served and within the capability of each physical location. (1-1-08)T

b. The plan must consider the performance of structural and critical non-structural building systems and the likelihood of loss of externally supplied power, gas, water, sanitary sewer, and communications under local or regional disaster situations. (1-1-08)T

c. The plan must contain the following elements: (1-1-08)T

i. Storage or a functional contingency plan to obtain; food, sterile supplies, pharmacy supplies, linen, and water for sanitation, sufficient for four (4) days; (1-1-08)T

ii. A procedure for notifying and assigning personnel; (1-1-08)T

iii. Unified medical command; (1-1-08)T

iv. Space and procedure for decontamination and triage; (1-1-08)T

v. Procedure for casualty transfer to an appropriate facility; (1-1-08)T

vi. Agreement with other agencies for communications. (1-1-08)T

d. The External Disaster Plan for the FSED may be an annex or appendix to the Hospital Plan, copies of which must be maintained onsite at the FSED. (1-1-08)T

12. Internal Disaster Plans. (1-1-08)T

a. The hospital and FSED must conduct a hazard vulnerability analysis and develop a plan for internal disasters for the building and personnel assigned to function in each physical location. The plan must consider the performance of the facility in dealing with an internal emergency such as the loss of building systems, supplied power, gas, vacuum, domestic water, blocked sanitary sewer, and loss of building communications. The plan must contain the following elements: (1-1-08)T

i. Those listed in Subsections 378.11. a. through d., of these rules; (1-1-08)T

ii. Back up communications; (1-1-08)T

iii. Building security and lockdown; (1-1-08)T

iv. Internal traffic and crowd control; (1-1-08)T

v. Loss of, or isolation of, other related departments; and (1-1-08)T

vi. Evacuation or relocation security. (1-1-08)T

b. Drills. The plans must be exercised annually at the FSED. (1-1-08)T

c. The Internal Disaster Plan for the FSED may be an annex or appendix to the Hospital Plan, copies of which must be maintained on site at the freestanding emergency department. (1-1-08)T

13. Preventative Maintenance. The FSED must be equipped and maintained to protect the health and safety of the patient, personnel, and visitors. The FSED must have a written preventive maintenance program to include at least the following elements: (1-1-08)T

a. Designation of person responsible for maintaining the facility; (1-1-08)T

b. Written preventive maintenance procedures and appropriate inspection intervals in accordance with NFPA 99 and additional mandatory references listed in NFPA 101, 2006 Edition

must be made for at least the following: (1-1-08)T

i. Heating systems; (1-1-08)T

ii. Air conditioning and mechanical systems; (1-1-08)T

iii. Electrical systems; (1-1-08)T

iv. Vacuum systems and gas systems; (1-1-08)T

v. All air filters in heating, air conditioning and ventilating systems; and (1-1-08)T

vi. Equipment related directly and indirectly to patient care, and any other equipment deemed essential under the emergency plan. (1-1-08)T

c. Maintenance and testing of Essential Electrical System, Vacuum, and Gas Systems must be in accordance with National Fire Protection Association 99; Health Care Facilities, 2005 Edition. (1-1-08)T

14. Safety. The FSED and hospital must have a safety committee and must be responsible for at least the following: (1-1-08)T

a. There must be comprehensive written safety procedures for all areas of the FSED which must include the safe use of equipment and handling of patients; (1-1-08)T

b. Safety orientation of new employees; and (1-1-08)T

c. Establishment of an incident or accident system for all patients, personnel, and visitors, that includes: (1-1-08)T

i. Reporting procedure; (1-1-08)T

ii. Investigation of incidents or accident; (1-1-08)T

iii. Documentation of investigation and disposition; and (1-1-08)T

iv. Evaluation of incidents or accidents and implementation of mitigation efforts. (1-1-08)T

379. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.03 - RULES GOVERNING FEES FOR COMMUNITY MENTAL HEALTH SERVICES

DOCKET NO. 16-0403-0801 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY FEE RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2008.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 39-3133, 39-3137, and 56-1007, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than January 16, 2008.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This chapter of rule is being repealed to avoid confusion and duplication with a chapter of rules being promulgated under IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules," published in this Administrative Bulletin under Docket No. 16-0701-0801.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

To avoid confusion and duplication with a chapter of rules promulgated under IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules."

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. This rulemaking has no anticipated fiscal impact to state general funds.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because these rules are being repealed.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Scott Tiffany at (208) 332-7243.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before January 23, 2008.

DATED this 26th day of October, 2007.

Sherri Kovach
Program Supervisor
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450 West State Street - 10th Floor
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IDAPA 16.04.03 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.01 - BEHAVIORAL HEALTH SLIDING FEE SCHEDULES

DOCKET NO. 16-0701-0801 (FEE RULE - NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY FEE RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2008.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Sections 16-2433, 19-2524, 20-520(i), 20-511A, 39-3137, and 39-309, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than January 16, 2008.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

This new chapter of rules updates the sliding fee scales for the adult mental health, children's mental health, and alcohol and substance use disorders programs and aligns them with the most current version of the federal poverty guidelines. This chapter also implements a fee schedule for persons convicted of a felony or serving on probation or parole.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because legislation passed during the 2007 Legislature (SB 1149) that requires the Department to implement a fee schedule for persons convicted of a felony or serving on probation or parole.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein:

Felony offenders in need of assessment, evaluation, and treatment services are being required to pay for a portion of their treatment based on their ability to pay. This rulemaking sets the schedule for these sliding fees based on federal poverty guidelines. Without this rule, access to services may be limited which increases the risk for offenders to endanger themselves and others.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

The fiscal impact of this change is a decrease of $2,126 in fee collection for Children's

Mental Health services, which must be met by state general funds. The estimated fiscal impact on receipts collected for Adult Mental Health services is $33,672. This fiscal impact is a decrease in collection of fees for the Adult Mental Health services. Neither of these funds will be replaced. There is no anticipated fiscal impact to the alcohol and substance disorders program.

Changes to the computerized billing system to update the current fee table used by the Daily Activity Report (DAR) automated system will be required. The estimated cost to update the fee table will be an annual cost of approximately $1000.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rulemaking is being implemented to meet the requirements of newly-passed legislation.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Scott Tiffany, Division of Behavioral Health, at (208) 332-7243.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before January 23, 2008.

DATED this 15th day of November, 2007.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-6558 fax
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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

IDAPA 16
TITLE 07
CHAPTER 01

16.07.01 - BEHAVIORAL HEALTH SLIDING FEE SCHEDULES

000. LEGAL AUTHORITY.
Under Sections 16-2433, 19-2524, 20-520(i), 20-511A, and 39-3137, Idaho Code, the Director is

authorized to promulgate, adopt, and enforce rules for the charging of fees for services provided by mental health and substance use disorders providers. Under Section 39-309, Idaho Code, the Board of Health and Welfare is authorized to promulgate, adopt, and enforce rules for the charging of fees for services provided by mental health and substance use disorders providers. (1-1-08)T

001. TITLE AND SCOPE.

01. Title. The title of this chapter of rules is IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." (1-1-08)T

02. Scope. These rules provide the sliding fee schedules, based on federal poverty guidelines, and fee determination process for the adult mental health, children's mental health, and substance use disorders programs within the Department. This chapter of rules applies both to voluntary and court-ordered recipients. (1-1-08)T

002. WRITTEN INTERPRETATIONS.
There are no written interpretations for these rules. (1-1-08)T

003. ADMINISTRATIVE APPEALS AND COMPLAINT PROCEDURE.
Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (1-1-08)T

004. INCORPORATION BY REFERENCE.
No documents have been incorporated by reference in this chapter of rules. (1-1-08)T

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEB SITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the State of Idaho. (1-1-08)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (1-1-08)T

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (1-1-08)T

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (1-1-08)T

05. Internet Web Site. The Department's internet web site is found at http://www.healthandwelfare.idaho.gov. (1-1-08)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and

Disclosure of Department Records." (1-1-08)T

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (1-1-08)T

007. -- 009. (RESERVED).

010. DEFINITIONS.
For the purposes of this chapter, the following definitions apply. (1-1-08)T

01. Ability to Pay. The financial capacity that is available to pay for the program services after allowable deductions in relation to gross income and family size exclusive of any liability of third party payor sources. (1-1-08)T

02. Adjusted Gross Income. Total family annual income less allowable annual deductions. (1-1-08)T

03. Adult. An individual 18 years of age or older. (1-1-08)T

04. Adult Mental Health Program. A program administered by the Idaho Department of Health and Welfare to serve severely and persistently mentally ill adults.(1-1-08)T

05. Allowable Deductions. In determining a person's ability to pay for services, acceptable adjustments to income which are limited to the following: (1-1-08)T

a. Court-ordered obligations paid annually; and (1-1-08)T

b. Annual dependent support payments; and (1-1-08)T

c. Annual child care payments necessary to availability of employment; and (1-1-08)T

d. Annual medical expenses. (1-1-08)T

06. Behavioral Health Services. Services offered by the Department to improve behavioral health issues or alcohol and substance use disorders. (1-1-08)T

07. Child. An individual under eighteen (18) years. (1-1-08)T

08. Children's Mental Health Program. A program administered by the Idaho Department of Health and Welfare to serve children with serious emotional disturbance. (1-1-08)T

09. Client. The recipient of services. The term "client" is synonymous with the terms: patient, participant, resident, consumer, or recipient of treatment. (1-1-08)T

10. Court-Ordered Obligations. Financial payments which have been ordered by a court of law. (1-1-08)T

11. Court-Ordered Recipient. A person receiving behavioral health services under Sections 19-2524, 20-520(i), and 20-511A, Idaho Code. (1-1-08)T

12. Department. The Idaho Department of Health and Welfare. (1-1-08)T

13. Dependent Support. An individual that is dependent on his family's income for over fifty percent (50%) of his financial support. (1-1-08)T

14. Extraordinary Rehabilitative Expenses. Those payments incurred as a result of the disability needs of the person receiving services. They include annual costs for items including, but not limited to, wheelchairs, adaptive equipment, medication, treatment, or therapy which were not included in the medical payments deduction and the annual estimate of the cost of services received. (1-1-08)T

15. Family. A family is an adult, or married adults, or adult(s) with children, living in a common residence. (1-1-08)T

16. Family Household. Persons in a family related by blood, marriage, or adoption. Step parents, step children, adult siblings, and individuals receiving Supplemental Security Income (SSI) are excluded from consideration as a member of the household for income and counting purposes. Income from minor siblings is excluded from household income. The term "family household" is synonymous with the term family unit. (1-1-08)T

17. Federal Poverty Guidelines. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income amount for family units considering the number of persons in the family household. (1-1-08)T

18. Legal Guardian. A representative appointed by a court of law who is responsible for making decisions related to another person. (1-1-08)T

19. Parent. The person who, by birth or through adoption, is legally responsible for a child. (1-1-08)T

20. Recipient. The person receiving services. The term "recipient" is synonymous with the terms: patient, participant, resident, consumer, or client. (1-1-08)T

21. Serious Emotional Disturbance. An emotional or behavioral disorder or a neuropsychiatric condition which results in a serious disability, which requires sustained treatment interventions and causes the child's functioning to be impaired in at least one (1) of the following areas: thought, perception, affect and behavior. A disorder is considered to be a serious disability if it causes substantial impairment in functioning. Functional impairment is assessed using the Child and Adolescent Functional Assessment Scale (CAFAS). Substantial impairment requires a full eight (8) scale score of eighty (80) or higher with "moderate" impairment in at least one (1) of the following three (3) scales: self-harmful behavior, moods/emotions, or thinking. A substance abuse disorder, conduct disorder, or developmental disorder, alone does not constitute a

serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. (1-1-08)T

22. Sliding Fee Scale. A scale used to determine an individual's cost for services based on Federal Poverty Guidelines and the number of persons in the family household. (1-1-08)T

23. Substance Use Disorders Program. A program administered by the Idaho Department of Health and Welfare to serve adolescents and adults with alcohol or substance use disorders. (1-1-08)T

24. Third-Party Payer. A payer other than a person receiving services or a responsible party who is legally liable for all or part of the person's care. (1-1-08)T

011. -- 099. (RESERVED).

100. CHARGES FOR CHILDREN'S MENTAL HEALTH SERVICES.
Parents or legal guardians of children with serious emotional disturbance who receive services either directly from the Department's Children's Mental Health program or through Department contracts with private providers are responsible for paying for services provided to their child and to their family. The amount charged for each service will be in accordance with the child's parent(s) or legal guardian(s) ability to pay as determined by the sliding fee scale in Section 300 of these rules. (1-1-08)T

101. -- 199. (RESERVED).

200. CHARGES FOR ADULT MENTAL HEALTH SERVICES.
Adults receiving services either directly from the Department's Adult Mental Health program or through Department contracts with private providers are responsible for paying for services they receive. The amount charged for each service will be in accordance with the individual's ability to pay as determined by the sliding fee scale in Section 300 of these rules. (1-1-08)T

201. -- 299. (RESERVED).

300. SLIDING FEE SCHEDULE FOR CHILDREN AND ADULT MENTAL HEALTH SERVICES.
Following is the sliding fee schedule for children and adult mental health services:

TABLE 300 - SLIDING FEE SCHEDULE FOR CHILDREN AND ADULT MENTAL HEALTH SERVICES.

Percent of Poverty	Percentage of Cost Sharing Responsibility of a Parent, Guardian, or Adult Client
0% - 99%	0%
100%-109%	5%

TABLE 300 - SLIDING FEE SCHEDULE FOR CHILDREN AND ADULT MENTAL HEALTH SERVICES.	
Percent of Poverty	**Percentage of Cost Sharing Responsibility of a Parent, Guardian, or Adult Client**
110%-119%	10%
120%-129%	15%
130%-139%	20%
140%-149%	25%
150%-159%	30%
160%-169%	35%
170%-179%	40%
180%-189%	45%
190%-199%	50%
200% - 209%	55%
210% - 219%	60%
220% - 229%	65%
230% - 239%	70%
240% - 249%	75%
250% - 259%	80%
260% - 269%	85%
270% - 279%	90%
280% - 289%	95%
290% - and above	100%

(1-1-08)T

301. -- 399. (RESERVED).

400. CALCULATING INCOME TO APPLY THE SLIDING FEE SCHEDULE FOR CHILDREN'S MENTAL HEALTH AND ADULT MENTAL HEALTH SERVICES.
Prior to the delivery of behavioral health services, an application for services and a "Fee Determination" form must be completed by a child's parent(s) or legal guardian(s) when requesting Children's Mental Health services and by adults requesting Adult Mental Health services. The fee determination process includes the following considerations: (1-1-08)T

01. Ability to Pay. Charges are based upon the number of persons in the family household and the income of those persons as determined using the following: (1-1-08)T

a. An ability to pay determination will be made at the time of the voluntary request for services or as soon as possible, thereafter. (1-1-08)T

b. Redetermination of ability to pay will be made at least annually or upon request of the parent(s) or legal guardian(s) or at any time changes occur in family size, income, or allowable deductions. (1-1-08)T

c. In determining the family's ability to pay for services, the Department will deduct annualized amounts for the following: (1-1-08)T

i. Court-ordered obligations; (1-1-08)T

ii. Dependent support; (1-1-08)T

iii. Child care payments necessary for parental or legal guardian employment; (1-1-08)T

iv. Medical expenses; (1-1-08)T

v. Transportation; (1-1-08)T

vi. Extraordinary rehabilitative expenses; and (1-1-08)T

vii. State and federal tax payments, including FICA taxes. (1-1-08)T

d. Information regarding third-party payors and other resources, including Medicaid or private insurance, must be identified and developed in order to fully determine the child's parent(s), legal guardian(s), or adult client's ability to pay and to maximize reimbursement for the cost of services provided. (1-1-08)T

e. It is the responsibility of the parents, guardian or adult client to obtain and provide information not available at the time of the initial financial interview whenever that information becomes available. (1-1-08)T

02. Time of Payment. Payment for services will be due upon delivery of services unless other arrangements are made. (1-1-08)T

03. Charges. Using the sliding fee scale in Section 300 of this rule, an amount will be charged based on family size, resources, income, assets and allowable deductions, exclusive of third-party liable sources, but in no case will the amount charged exceed the cost of the service. (1-1-08)T

04. Fees Established By the Department. The maximum hourly fees or flat fees charged for Children's Mental Health services and Adult Mental Health services are established by the Department of Health and Welfare. The fees for services based on Medicaid reimbursement rates may vary according to Medicaid inflationary increases. Fees will be reviewed and adjusted as the Medicaid rates change. Current information regarding services and fee charges can be obtained from regional Children's Mental Health and Adult Mental Health offices. (1-1-08)T

401. -- 499. (RESERVED).

500. SLIDING FEE SCHEDULE FOR ALCOHOL AND SUBSTANCE USE DISORDERS TREATMENT SERVICES.
Adult clients above one hundred seventy-five (175%) poverty are not eligible for services. Following is the sliding fee schedule for adolescent and adult alcohol and substance use disorders treatment services:

TABLE 500 - SLIDING FEE SCHEDULE FOR ALCOHOL AND SUBSTANCE USE DISORDERS TREATMENT SERVICES.

Percent of Poverty	Percentage of Cost Sharing Responsibility of a Parent, Guardian, or Adult Client
0% - 99%	5%
100% - 104%	10%
105% - 114%	20%
115% - 124%	30%
125% - 134%	40%
135% - 144%	50%
145% - 154%	60%
155% - 164%	65%
165% - 175%	70%

(1-1-08)T

501. -- 599. (RESERVED).

600. CALCULATING INCOME TO APPLY THE SLIDING FEE SCHEDULE FOR ALCOHOL AND SUBSTANCE DISORDERS SERVICES.

01. Ability to Pay. Charges are based upon the number of dependents and family income. (1-1-08)T

a. An ability to pay determination will be made at the time of the voluntary request for services or as soon as possible. (1-1-08)T

b. Redetermination of ability to pay will be made at least annually or upon request demonstrating that a substantial material change of circumstances has occurred in family size, income, or allowable deductions. (1-1-08)T

c. In determining an individual's ability to pay for services, the Department will deduct annualized amounts for: (1-1-08)T

i. Court-ordered obligations; (1-1-08)T

ii. Dependent support; (1-1-08)T

iii. Child care payments necessary for employment; (1-1-08)T

iv. Medical expenses; (1-1-08)T

v. Transportation; (1-1-08)T

vi. Extraordinary rehabilitative expenses; and (1-1-08)T

vii. State and federal tax payments, including FICA. (1-1-08)T

d. Information regarding third-party payors and other resources including Medicaid, or private insurance must be identified and developed in order to fully determine the individual's ability to pay and to maximize reimbursement for the cost of services provided. (1-1-08)T

e. It is the responsibility of the individual requesting alcohol or substance use disorder services to obtain and provide information not available at the time of the initial financial interview whenever that information becomes available. (1-1-08)T

02. Time of Payment. Payment for services is due thirty (30) days from the date of the billing, unless other arrangements are made. (1-1-08)T

03. Charges. Using the sliding fee scale in Section 500 of this rule, an amount will be charged based on family size, resources, income, assets, and allowable deductions, exclusive of third-party liable sources. In no case will the amount charged exceed the costs of the services. (1-1-08)T

04. Established Fee. The maximum hourly fees or flat fees charged for alcohol or substance use disorder services will be established by the Department in collaboration with the Interagency Committee on Substance Abuse Prevention and Treatment and the Board of Health and Welfare. (1-1-08)T

601. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.10 - BEHAVIORAL HEALTH DEVELOPMENT GRANTS

DOCKET NO. 16-0710-0801 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2008.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 39-3133, 39-3134A, and 39-3136, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than January 16, 2007.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The Legislature has designated the Department of Health and Welfare as the State Mental Health Authority and has given it the responsibility to help improve, expand, and modify the mental health and substance abuse treatment services delivery system. Funds are appropriated by the Legislature for distribution to regional and community treatment model services in the form of grants. This chapter of rules will provide the framework for grant application requirements, criteria, and distribution for grants to meet the mental health and substance abuse treatment services needed to improve services unique to each region. The regional mental health boards and a development grant advisory group will be utilized to assist in the evaluation and award process of the grants as provided in these rules.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

These rules are needed to meet statutory requirements and to confer a benefit through grant money appropriated by the Legislature to improve mental health services statewide.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

Funds for these grants are set and appropriated by the Legislature. This rulemaking has no anticipated additional fiscal impact to the Department.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the Legislature authorized the Department to set procedures for awarding grants.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Scott Tiffany at (208) 332-7243.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before January 23, 2008.

DATED this 16th day of November, 2007.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-6558 fax
kovachs@dhw.idaho.gov e-mail

THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

IDAPA 16
TITLE 07
CHAPTER 10

16.07.10 - BEHAVIORAL HEALTH DEVELOPMENT GRANTS

000. LEGAL AUTHORITY.

The Idaho Legislature has delegated to the Department of Health and Welfare, as the State Mental Health Authority, the responsibility to administer grant funds appropriated for mental health and substance abuse treatment services as provided in Sections 39-3136 and 39-3134A, Idaho Code. Under Section 39-3133, Idaho Code, the Director of the Department of Health and Welfare is authorized to promulgate rules to carry out the purposes and intent of the Regional Mental Health Services Act. (1-1-08)T

001. TITLE, SCOPE, AND OBJECTIVE.

01. Title. The title of these rules is IDAPA 16.07.10, "Behavioral Health Development Grants." (1-1-08)T

02. Scope. These rules establish the process and procedures to be used in applying for and awarding behavioral health development grants through the State Mental Health Authority under Title 39, Chapter 31, Idaho Code. Funding is limited and the grant application process is competitive in nature. The applicant must strictly comply with the grant application process and these rules in order for the application to be reviewed and considered. This chapter is not intended to and does not establish an entitlement for or receipt of behavioral health development grant funding. (1-1-08)T

03. Objective. The objective of behavioral health development grant funding is to assist the State Mental Health Authority in developing substance abuse or mental health treatment services outlined in Section 39-3128, Idaho Code, including twenty-four (24) hour psychiatric emergency services, short-term psychiatric beds, crisis intervention teams, transitional housing and detoxification facilities as provided in Section 39-3134A(3), Idaho Code. (1-1-08)T

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), the Department may have written materials pertaining to the interpretation of this chapter of rules. These materials are available for public inspection and copying at cost in the Department's main office, as described in Sections 005 and 006 of these rules. (1-1-08)T

003. APPEALS.

01. Award Determinations and Grant Decisions. The Department may grant, in whole or in part, deny, suspend, revoke, terminate, reserve, limit, define grant criteria, establish scoring criteria, set the terms and conditions of grant agreements, and the number of programs or entities eligible for behavioral health development grants according to Sections 39-3133 and 39-3134A(3), Idaho Code. (1-1-08)T

02. Reconsideration. The Director may, upon a timely written request, reconsider an award determination or a decision, order, or action concerning a behavioral health development grant as provided in Sections 250 and 260 of these rules. (1-1-08)T

03. Final Order. The Director's decision on reconsideration constitutes a final order of the Department which is not subject to administrative or judicial review. *Maresh v. State*, 132 Idaho 221, 970 P.2d 14 (Idaho 1999). (1-1-08)T

004. INCORPORATION BY REFERENCE.
No documents are incorporated by reference in this chapter. (1-1-08)T

005. OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE -- WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (1-1-08)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (1-1-08)T

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (1-1-08)T

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (1-1-08)T

05. Internet Website. The Department's internet website is found at http://www.healthandwelfare.idaho.gov. (1-1-08)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. Any information covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." (1-1-08)T

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (1-1-08)T

007. -- 009. (RESERVED).

010. DEFINITIONS.
For the purposes of this chapter, the following definitions apply. (1-1-08)T

01. Administrator. The Administrator of the Division of Behavioral Health, Department of Health and Welfare, or designee. (1-1-08)T

02. Applicant. A person or entity submitting an application for the purpose of requesting a behavioral health development grant from the Department. (1-1-08)T

03. Application Period. The period of time specified in the grant application, or, if no date is specified, the period from July 1 to August 1 of the fiscal year for which funding is requested. (1-1-08)T

04. Appropriations. Behavioral health funding as set by the Legislature each fiscal year for the Department. (1-1-08)T

05. Department. The Idaho Department of Health and Welfare or its designee. The Department is designated as the State Mental Health Authority under Section 39-3124, Idaho Code. (1-1-08)T

06. Development Grant Review Committee. A committee composed of representatives from the Department of Correction, the Department of Juvenile Corrections, the courts, and the Department of Health and Welfare as designated in Section 39-3134A(3), Idaho Code. (1-1-08)T

07. Director. The Director of the Idaho Department of Health and Welfare or designee. (1-1-08)T

08. Eligible Entity. A legal entity or person, not including a state agency or subdivision of a state agency, which provides substance abuse or mental health treatment services outlined in Section 39-3128, Idaho Code, including twenty-four (24) hour emergency psychiatric services, short-term psychiatric beds, crisis intervention teams, transitional housing and detoxification facilities. (1-1-08)T

09. Fiscal Year. The State of Idaho's accounting period that consists of twelve (12) consecutive months from July 1 through June 30 of the next year. (1-1-08)T

10. Grantee. A person or entity awarded grant funds under these rules. (1-1-08)T

11. Regional Mental Health Board. A regional mental health board for each region or service area consisting of fourteen (14) members in accordance with Section 39-3130, Idaho Code. (1-1-08)T

011. -- 049. (RESERVED).

050. REGIONAL SERVICE AREAS.
Idaho has seven (7) regions or service areas for grant distribution purposes. (1-1-08)T

01. Region I - Behavioral Health. The counties of Benewah, Bonner, Boundary, Kootenai, and Shoshone. (1-1-08)T

a. Region I Office Address: 2195 Ironwood Court, Coeur d'Alene, ID 83814. (1-1-08)T

b. Phone: (208) 769-1406. (1-1-08)T

02. Region II - Behavioral Health. The counties of Clearwater, Idaho, Latah, Lewis, and Nez Perce. (1-1-08)T

a. Region II Office Address: 1118 "F" Street, P. O. Drawer B, Lewiston, ID 83501. (1-1-08)T

b. Phone: (208) 799-4440. (1-1-08)T

03. Region III - Behavioral Health. The counties of Adams, Canyon, Gem, Owyhee, Payette, and Washington. (1-1-08)T

a. Region III Office Address: 3402 Franklin Rd., Caldwell, ID 83605. (1-1-08)T

b. Phone: (208) 459-0092. (1-1-08)T

04. Region IV - Behavioral Health. The counties of Ada, Boise, Elmore, and Valley. (1-1-08)T

a. Region IV Office Address: 1720 Westgate Dr., Boise, ID 83704. (1-1-08)T

b. Phone: (208) 334-0893. (1-1-08)T

05. Region V - Behavioral Health. The counties of Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Falls. (1-1-08)T

a. Region V Office Address: 823 Harrison Dr., Twin Falls, ID 83301. (1-1-08)T

b. Phone: (208) 736-2177. (1-1-08)T

06. Region VI - Behavioral Health. The counties of Bannock, Bear Lake, Bingham, Caribou, Franklin, Oneida, and Power. (1-1-08)T

a. Region VI Office Address: 421 Memorial Drive, Pocatello, ID 83204. (1-1-08)T

b. Phone: (208) 234-7900. (1-1-08)T

07. Region VII - Behavioral Health. The counties of Bonneville, Butte, Clark, Custer, Fremont, Jefferson, Lemhi, Madison, and Teton. (1-1-08)T

a. Region VII Office Address: 150 Shoup, Ste. 19, Idaho Falls, ID 83402. (1-1-08)T

b. Phone: (208) 528-5700. (1-1-08)T

051. -- 059. (RESERVED).

060. GRANT CYCLE AND TIME FRAMES.

01. Notification of Annual Grants and Grant Applications. Subject to appropriations and available funding, under Title 39, Chapter 31, Idaho Code, the Department will publish a notice announcing available behavioral health development grants in a major daily newspaper in each regional service area prior to the beginning of the fiscal year. The notice will specify the available award amount, the closing date for submission of the grant application, and how to obtain grant application forms. The closing date for submission of applications will be no later than August 1 of the fiscal year in which funding is appropriated. (1-1-08)T

02. Grant Application Submission. A grant application must be submitted to the Department no later than the date designated in the grant application. If no date is specified in the grant application, the application is due no later than August 1 of the fiscal year in which funding is requested. Applications not submitted within these time limits will be excluded from

consideration for grant awards. (1-1-08)T

03. Unawarded Grant Funds. Subject to remaining or supplemental funding, the Department may commence another grant award cycle, if time allows. In the event there is insufficient time left in the fiscal year to complete another grant cycle, available funding may be allocated on a pro-rated basis to successful grant recipients or ranked applicants for the fiscal year in which the funding is available. (1-1-08)T

04. Unused Grant Funds. All funds not expended in compliance with the terms and conditions of an applicant's award and grant agreement must be returned to the Department within thirty (30) days of the end of the grant's terms and conditions. (1-1-08)T

061. -- 099. (RESERVED).

100. BEHAVIORAL HEALTH DEVELOPMENT GRANTS.

01. Develop a Statewide Plan. The Department, as provided in Title 39, Chapter 31, Idaho Code, and under these rules, will develop a statewide plan for grants in coordination with the other members of the development grant advisory group and from recommendations of the State Planning Council on Mental Health and Regional Mental Health Boards. (1-1-08)T

02. Grant Applications. The Department will provide grant application forms, guidelines, and other necessary information no later than July 1 of each fiscal year in which funds have been appropriated. (1-1-08)T

03. Grant Guidelines and Criteria. The Department will specify the guidelines and the criteria for each type of grant that is available for the fiscal year in the grant application form. (1-1-08)T

04. Grant Evaluation, Weighting, and Ranking Process. The Department will set the evaluation criteria, weighting, and the ranking process to be used each year, based on the needs of the regional mental health service areas and statewide needs. (1-1-08)T

101. -- 109. (RESERVED).

110. GRANT APPLICATION PROCESS.

01. Application. In order to be considered for a grant award, the applicant must submit an original and eight (8) copies of the completed grant application, including a letter of support from the appropriate Regional Mental Health Board, as provided in Section 120 of these rules. (1-1-08)T

02. Required Information. Only applications on forms and in formats approved by the Department will be considered for funding. An application that is missing required information will be excluded from consideration for a grant award. (1-1-08)T

03. Application Purpose. The grant application and any attachments submitted by the applicant are the primary sources of information for awarding a grant. (1-1-08)T

04. Limitations. The following limitations in Subsections 110.04.a. and 110.04.b. of this rule apply to all applications. (1-1-08)T

a. A person or legal entity is not eligible to apply for a grant if there are any unresolved audit findings or prior unresolved performance issues from previous grants. (1-1-08)T

b. An applicant must receive a letter of support for behavioral health development grant funding from the appropriate Regional Mental Health Board for projects located in the region where the services will be provided. An application cannot be submitted on behalf of a person or entity located in other regions or service areas solely for administrative convenience. (1-1-08)T

05. Delivery of Applications. The application must be delivered to the Department as described in Section 005 of these rules. Any application not meeting the closing date requirements will be disqualified. Applications will be considered to have been timely received under one (1) of the following: (1-1-08)T

a. An application sent by mail or private commercial carrier no later than the closing date, as evidenced by a U.S. Postal Service date postmark or by a commercial carrier date stamp. An applicant is responsible for obtaining postmark or commercial carrier date stamps; or (1-1-08)T

b. A hand-delivered application will be accepted during normal business working hours. In establishing the date of receipt of hand-delivered applications, reliance will be placed on documentary evidence of receipt maintained by the Department. (1-1-08)T

111. -- 119. (RESERVED).

120. REGIONAL RECOMMENDATION BY THE REGIONAL MENTAL HEALTH BOARD.

01. Regional Review. Each Regional Mental Health Board will review and make recommendations to the Development Grant Review Committee on grant proposals to provide services in its region. (1-1-08)T

02. Regional Recommendation. Each Regional Mental Health Board will determine which grant proposals to recommend for its region. The Regional Mental Health Board will provide a written recommendation of support to the Development Grant Review Committee for each grant proposal it supports. The applicant must include this recommendation of support with the grant application. (1-1-08)T

03. No Regional Support. A grant application not receiving a written recommendation of support from the appropriate Regional Mental Health Board is not complete and will not be considered for grant awards. (1-1-08)T

121. -- 129. (RESERVED).

130. STATEWIDE RECOMMENDATION BY THE DEVELOPMENT GRANT REVIEW COMMITTEE.

01. Statewide Review. Based upon a timely received application and written recommendation of support from the appropriate Regional Mental Health Board, the Development Grant Review Committee will rank the applications on a statewide basis and make recommendations to the Administrator. (1-1-08)T

02. Statewide Ranking. The Development Grant Review Committee will rank applications using such factors as availability of funding, the degree of financial need, the degree of need in the regions and the state, or other factors, including the criteria contained in the grant review and ranking section of the applicable grant application. The applications will be ranked from highest to lowest priority on a statewide basis. (1-1-08)T

03. Statewide Recommendation. The Development Grant Review Committee will provide the ranking of applications to the Administrator no later than forty-five (45) days following the closing date designated in the grant application, or no later than September 15 of the fiscal year in which funding is requested. (1-1-08)T

131. -- 199. (RESERVED).

200. GRANT AWARD AND SCHEDULE.

01. Determination of Grant Awards. Absent good cause, the Administrator will award grants on a statewide basis in accordance with the written recommendations of the Development Grant Review Committee and in the amounts approved by the Development Grant Review Committee, until either the grants have been awarded for all ranked applications or there is no more money available in the funding appropriation, whichever occurs first. (1-1-08)T

02. Notification. The Department will notify all applicants in writing of the disposition of their grant applications by October 1 of the fiscal year in which funding is requested. Notice of a grant award is not a guarantee of present or future funding. (1-1-08)T

03. Awarding of Grants. Grant awards will be formalized through an agreement specifying, at a minimum, the eligible activities for which the grant is to be awarded, the amount of the grant award, the schedule of deliverables and payments, and any additional terms and conditions established by the Department. (1-1-08)T

04. Acceptance of Grant Award by Grantee. Acceptance of the grant award is accomplished by returning two (2) copies of the agreement bearing the original signature of a duly authorized representative of the grantee. The copies of the signed agreement are to be returned to the Department within ten (10) business days of the date of the letter transmitting the agreement to the grantee. (1-1-08)T

05. Disbursement. Funds for approved grants will be disbursed in accordance with the schedule of payments established in each grant agreement. (1-1-08)T

06. No Continued Obligation. Neither the approval of any project nor any grant award will commit or obligate the Department in any way to make any additional, supplemental, continuation, or other awards with respect to any project, proposed project, or portion of the project. A grantee must make separate application in accordance with each grant application and these rules. (1-1-08)T

07. Not a Waiver. Failure of the Department to require strict compliance will not be considered a waiver of requirements of these rules or in the grant application. (1-1-08)T

201. -- 249. (RESERVED).

250. RECONSIDERATION OF GRANT APPLICATION.
No later than fifteen (15) days from the date of written notification from the Department of its award determination, an applicant or a grantee may file a written request for reconsideration with the Director. (1-1-08)T

01. Contents of Request for Reconsideration. Any request for reconsideration must contain all pertinent facts supporting the applicant's or the grantee's request for the Director to reconsider and must set forth with specificity all of the facts and reasons that demonstrate the Department's award determination was arbitrary and capricious. (1-1-08)T

02. Disposition of Request for Reconsideration. Upon notification of a timely request for reconsideration, the Director will review the request and all relevant data upon which the Department based its award determination. (1-1-08)T

03. Disposition of Funds Pending Reconsideration. While a timely and valid request for reconsideration is pending, an amount equal to the grant request under reconsideration will be reserved by the Department. This reserve is established by withholding funds on a pro-rated basis from all successful grantees. (1-1-08)T

04. Issuance of Decision on Reconsideration. Following consideration of all relevant data, the Director will issue a written decision, within ten (10) business days of receiving a request for reconsideration. The Director's decision on reconsideration constitutes a final order of the Department which is not subject to judicial review. (1-1-08)T

251. -- 259. (RESERVED).

260. CORRECTIVE ACTION, TERMINATION, OR REDUCTION OF FUNDING.

01. Determination of Non-Compliance. The remedies set forth in this section are cumulative, are not exclusive, and are in addition to any other rights and remedies provided by law or under the grant agreement. If a grantee fails to comply with the terms of the grant application, grant agreement, these rules, or appropriate standards, goals, and other requirements, including performance objectives, the Department will inform the grantee of the deficiency and may take one (1) or more of the following actions: (1-1-08)T

a. Suspend grant funding pending an investigation to determine compliance with the grant application, grant agreement, these rules or appropriate standards, goals and other

requirements, including performance objectives; (1-1-08)T

b. Require the grantee to correct any deficiency; (1-1-08)T

c. If feasible, allow the grantee sixty (60) days to develop and implement a quality improvement plan to correct the deficiency within a reasonable period of time; or (1-1-08)T

d. Terminate or reduce funding and require the grantee to account for and return awarded grant funds to the Department. (1-1-08)T

02. Request for Reconsideration. No later than fifteen (15) days from the date of written notification of corrective action from the Department to a grantee denying, suspending, reducing, or terminating a grant award, a grantee may file a written request for reconsideration with the Director. (1-1-08)T

a. Any request for reconsideration must contain all pertinent facts supporting the grantee's request for the Director to reconsider and must set forth with specificity all of the facts and reasons that demonstrate the Department's corrective action was arbitrary and capricious. (1-1-08)T

b. Upon notification of a timely request for reconsideration, the Director will review the request and all relevant data upon which the Department based its original decision. (1-1-08)T

c. Following consideration of all relevant data, the Director will issue a written decision, within ten (10) business days of receiving a request for reconsideration. The Director's decision on reconsideration constitutes a final order of the Department which is not subject to judicial review. (1-1-08)T

261. -- 299. (RESERVED).

300. CONFLICT OF INTEREST.

01. General Policy. It is the policy of the Department that grant management and the award process be conducted in an equitable manner, and that public funds be expended in a fair, efficient, and effective manner. Every effort will be made to assure the public that no conflict of interest or appearance of impropriety exists. (1-1-08)T

02. Covered Person. These provisions for conflict of interest apply to any person who is an employee, agent, contractor, consultant, official, or officer of the Department, state, city, or county, or who is a member of a Regional Mental Health Board, a member of the Development Grant Review Committee, applicant, grantee, or any sub-grantee receiving funds. (1-1-08)T

03. Standard of Conduct. The general standard of conduct is to avoid any action or inaction that might result in, or create the appearance of, any impropriety or conflict of interest. In accordance with this general standard of conduct, a covered person will not vote on any matter in which he has any substantial ownership, potential for personal financial gain, fiduciary or contractual interest, or a direct competitive relationship. Any such relationship must be immediately disclosed as provided in Subsection 300.04 of this rule. (1-1-08)T

04. Disclosure Procedures. At or before any meeting during which a conflict of interest arises, a covered person must make a Declaration of a Conflict of Interest, or a potential conflict of interest, either by letter or verbal declaration, and it will be entered into the minutes of the meeting. The declaration must contain the nature of the conflict, the parties involved in the conflict, the impact of the conflict on their duties, and any proposed method of resolving the conflict. The covered person must then refrain from any discussion, recommendation, action, or voting on the matter. (1-1-08)T

301. -- 309. (RESERVED).

310. AUDITS.
The Department may conduct audits and determine the scope and depth of these audits. (1-1-08)T

311. -- 349. (RESERVED).

350. FRAUDULENT INFORMATION ON GRANT APPLICATION.
Providing false information on any application or document submitted under these rules is grounds for declaring the applicant ineligible, or for taking any and all remedial action, as provided in Section 260 of these rules. Any and all funds determined to have been acquired on the basis of fraudulent information must be returned to the Department immediately. (1-1-08)T

351. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.17 - ALCOHOL AND SUBSTANCE USE DISORDERS SERVICES

DOCKET NO. 16-0717-0801 - (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2008.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 39-311 and 56-1003, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than Wednesday, January 16, 2008. The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

In accordance with Executive Order 2006-18, the Department created a new Division of Behavioral Health. This new division is responsible for administering alcohol and substance use disorders services for adults and adolescents. Currently, there is no chapter pertaining to the oversight of alcohol and substance use disorders services and this new chapter is needed to fill that void.

This rulemaking is primarly being done because there is no formal appeal process in rule for adults or adolescents seeking services from the Department. This rulemaking provides this appeal process benefit and outlines how to appeal a denial of services decision made by the Department. This chapter also defines the scope of voluntary alcohol and substance use disorders services and describes the eligibility criteria, application requirements, individualized treatment plan, and selection of providers under these rules.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate as this rulemaking confers a benefit.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. **This rulemaking has no anticipated fiscal impact to the state general fund.**

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0717-0801***
Alcohol and Substance Use Disorders Services ***TEMPORARY RULE***

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this new chapter was developed primarily to establish the benefit of appeal rights for individuals receiving alcohol and substance use disorders services under these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Bethany Gadzinski, Division of Behavioral Health, at (208) 334-5756.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, January 23, 2008.

DATED this 5th day of November, 2007.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
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kovachs@dhw.idaho.gov e-mail

THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

IDAPA 16
TITLE 07
CHAPTER 17

16.07.17 - ALCOHOL AND SUBSTANCE USE DISORDERS SERVICES

000. LEGAL AUTHORITY.

The Idaho Legislature has delegated to the Board of Health and Welfare, the responsibility to ensure that clinically necessary alcohol and substance use disorder services are available throughout the state of Idaho to individuals who meet certain eligibility criteria under the Alcoholism and Intoxication Treatment Act, Title 39, Chapter 3, Idaho Code. Under Section 39-311, Idaho Code, the Board of Health and Welfare is authorized to promulgate rules to carry out the purpose and intent of the Alcoholism and Intoxication Treatment Act. Under Section 39-304, Idaho Code, the Department is authorized to establish a comprehensive and coordinated program for the treatment of alcoholics, intoxicated persons, and drug addicts to carry out the purposes and intent of the Alcoholism and Intoxication Treatment Act. Section 56-1003, Idaho Code authorizes the Director of the Department to administer services dealing with the problem of alcoholism and the rehabilitation of persons suffering from alcoholism. (1-1-08)T

001. TITLE AND SCOPE.

01. Title. The title of these rules is, IDAPA 16.07.17, "Alcohol and Substance Use Disorders Services." (1-1-08)T

02. Scope. This chapter defines the scope of voluntary services administered under the Department's Division of Behavioral Health, and describes the eligibility criteria, application requirements, individualized treatment plan requirements, selection of providers, and appeal process under these rules. This chapter is not intended to and does not establish an entitlement for or to receive adult or adolescent alcohol or substance use disorder services, nor is it intended to be applicable to individuals ordered by the court to receive alcohol or substance use disorder services. (1-1-08)T

002. WRITTEN INTERPRETATIONS.
There are no written interpretations for these rules. (1-1-08)T

003. ADMINISTRATIVE APPEALS.

01. Appeal of Denial Based on Eligibility Criteria. Administrative appeals from a denial of alcohol and substance use disorder services based on eligibility criteria and priority population are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (1-1-08)T

02. Appeal of Decision Based on Clinical Judgement. All decisions involving clinical judgment, including the category of services, the particular provider of services, or the duration of services, are reserved to Department, and are not subject to appeal, administratively or otherwise, in accordance with *Maresh v. State,* 132 Idaho 221, 970 P.2d 14 (Idaho 1999). (1-1-08)T

004. INCORPORATION BY REFERENCE.
The following are incorporated by reference in this chapter of rules: (1-1-08)T

01. ASAM PPC-2R. American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition - Revised (ASAM PPC-2R). A copy of this manual is available by mail at the American Society of Addiction Medicine, 4601 North Park Ave., Suite 101, Chevy Chase, MD 20815; by telephone and fax, (301) 656-3920 and (301) 656-3815 (fax); or on the internet at http://www.asam.org. (1-1-08)T

02. DSM-IV-TR. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (1-1-08)T

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEB SITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the State of Idaho. (1-1-08)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (1-1-08)T

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (1-1-08)T

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (1-1-08)T

05. Internet Web Site. The Department's internet web site is found at: http:// www.healthandwelfare.idaho.gov. (1-1-08)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." (1-1-08)T

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (1-1-08)T

007. -- 008. (RESERVED).

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History and Background Check. All current Department employees, applicants, transfers, reinstated former employees, student interns, contract employees, volunteers, and others assigned to programs that involve direct contact with children or vulnerable adults as described in Section 39-5302, Idaho Code, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-08)T

02. Availability to Work or Provide Service. Certain individuals are allowed to provide services after the self-declaration is completed as provided in Section 56-1004A, Idaho Code, except when they have disclosed a designated crime listed in IDAPA 16.05.06, "Criminal History and Background Checks." The criminal history check requirements applicable to each provider type are found in the rules that state the qualifications or certification of those providers. (1-1-08)T

010. DEFINITIONS.

For the purposes of these rules, the following terms are used as defined below: (1-1-08)T

01. Adolescent. An individual between the ages of fourteen (14) and eighteen (18). (1-1-08)T

02. Adult. An individual eighteen (18) years or older. (1-1-08)T

03. Applicant. An adult or adolescent individual who is seeking alcohol or substance use disorders services through the Department who has completed or had completed on his behalf an application for alcohol or substance use disorder services. (1-1-08)T

04. ASAM PPC-2R. Refers to the second edition, revised, manual of the patient placement criteria for the treatment of substance-related disorders, published by the American Society of Addiction Medicine. (1-1-08)T

05. Biopsychosocial Assessment. Those procedures by which a substance use disorder clinician evaluates an individual's strengths, weaknesses, problems, needs, and determines priorities so that a treatment plan can be developed. (1-1-08)T

06. Client. A person receiving treatment for an alcohol or substance use disorder. The term "client" is synonymous with the terms: patient, resident, consumer, or recipient of treatment. (1-1-08)T

07. Clinical Judgment. Refers to observations and perceptions based upon education, experience, and clinical assessment. This may include psychometric, behavioral, and clinical interview assessments that are structured, integrated, and then used to reach decisions, individually or collectively, about an individual's functional, mental, and behavioral attributes and alcohol and substance use disorders service needs. (1-1-08)T

08. Clinical Necessity. Alcohol or substance use disorder services are deemed clinically necessary when the Department, in the exercise of clinical judgment, would recommend services to an applicant for the purpose of evaluating, diagnosing, or treating alcohol or substance use disorders that are: (1-1-08)T

a. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for treating the applicant's alcohol or substance use disorder; and (1-1-08)T

b. Not primarily for the convenience of the applicant or service provider and not more costly than an alternative service or sequence of services and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the applicant's alcohol or substance use disorder. (1-1-08)T

09. Clinical Team. A proposed client's clinical team may include: qualified clinicians, behavioral health professionals, professionals other than behavioral health professionals, behavioral health technicians and any other individual deemed appropriate and necessary to ensure that the assessment and subsequent treatment is comprehensive and meets the needs of the proposed client. (1-1-08)T

10. Clinically Managed High-Intensity Residential Treatment. Frequently referred to as long term residential care or a Therapeutic Community, twenty-four (24) hour intensive residential program designed to treat persons who have significant social and psychological problems. Individuals who are appropriate for this level of care typically have multiple deficits, which may include criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. (1-1-08)T

11. Clinically Managed Low-Intensity Residential Treatment. Is a program that offers at least five (5) hours per week of outpatient or intensive outpatient treatment services along with a structured recovery environment, staffed twenty-four (24) hours per day, which provides sufficient stability to prevent or minimize relapse or continued use. This level of care is also known as a Halfway House. (1-1-08)T

12. Clinically Managed Medium-Intensity Residential Treatment. Frequently referred to as residential care, programs provide a structured, twenty-four (24) hour intensive residential program for clients who require treatment services in a highly structured setting. This type of program is appropriate for clients who need concentrated, therapeutic services prior to community residence. Community reintegration of residents in this level of care requires case management activities directed toward networking clients into community-based recovery support services such as housing, vocational services or transportation assistance so that the client is able to attend mutual/self-help meetings or vocational activities after discharge. (1-1-08)T

13. Contracted Intermediary. A third party contractor of the Department who handles direct contracting with network providers for treatment services to include network management, claims payment, data gathering per Federal and State requirements and census management. (1-1-08)T

14. Department. The Department of Health and Welfare or a person authorized to act on behalf of the Department. (1-1-08)T

15. Early Intervention Services. Early intervention services are designed to explore and address an adolescent's problems or risk factors that appear to be related to substance use, i.e., alcohol, tobacco, or other drugs, and to assist the adolescent in recognizing the harmful consequences of substance use. Early intervention services are intended to be a combination of prevention and treatment services for at-risk youth. (1-1-08)T

16. Emergency. An emergency exists if an adult or adolescent individual is gravely disabled due to mental illness or substance abuse or dependence or there is a substantial risk that physical harm will be inflicted by the proposed client: (1-1-08)T

a. Upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself; or (1-1-08)T

b. Upon another person as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm. (1-1-08)T

17. Federal Poverty Guidelines. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income amount for family

units considering the number of persons in the family unit. The federal poverty guidelines for the current year may be found at: http://aspe.hhs.gov/poverty/. (1-1-08)T

18. Functional Impairment. Difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, or functioning in social, family, vocational or educational contexts. (1-1-08)T

19. Gravely Disabled. An adult or adolescent who, as a result of mental illness or substance abuse or dependence, is in danger of serious physical harm due to the person's inability to provide for any of his basic needs for nourishment, or essential medical care, or shelter or safety. (1-1-08)T

20. Individualized Treatment Plan. A written action plan based on an intake eligibility screening and full clinical assessment, that identifies the applicant's clinical needs, the strategy for providing services to meet those needs, treatment goals and objectives and the criteria for terminating the specified interventions. (1-1-08)T

21. Intake Eligibility Screening. The collection of data, analysis, and review, which the Department, or its designee, uses to screen and determine whether an applicant is eligible for adult or adolescent alcohol or substance use disorder services available through the Department. (1-1-08)T

22. Intensive Outpatient Services. An organized service delivered by addiction professionals or addiction-credentialed clinicians, which provides a planned regimen of treatment consisting of regularly scheduled sessions within a structured program, for a minimum of nine (9) hours of treatment per week for adults and six (6) hours of treatment per week for adolescents. (1-1-08)T

23. Medical Detoxification. Means medically supervised twenty-four (24) hour care for patients who require hospitalization for treatment of acute alcohol intoxication or withdrawal, from one (1) or more other substances of abuse, and other medical conditions which together warrant treatment in this type of setting. Length of stay varies depending on the severity of the disease and withdrawal symptoms. (1-1-08)T

24. Network Treatment Provider. A treatment provider who has facility approval through the Department and is contracted with the Department’s Management Service Contractor. A list of network providers can be found at the Department’s website given in Section 005 of these rules. The list is also available by calling these telephone numbers: 1 (800) 922-3406; or dialing 211. (1-1-08)T

25. Outpatient Services. An organized non-residential service, delivered in a variety of settings, in which addiction treatment personnel provide professionally directed evaluation and treatment for alcohol and substance use disorders. (1-1-08)T

26. Priority Population. Priority populations are populations who receive services ahead of other persons and are determined yearly by the Department based on Federal regulations and input from the Interagency Committee on Substance Abuse Prevention and Treatment. A current list of the priority population is available from the Department. (1-1-08)T

27. Recovery Support Services. These services include: safe and sober housing that is staffed; transportation; child care; family education; life skills education; marriage education; drug testing; peer to peer mentoring; and clinical case management. (1-1-08)T

28. Residential Social Detoxification. Means a medically supported twenty-four (24) hour, social rehabilitation residential program which provides physical care, education, and counseling as appropriate for the client's health and safety during his process of physical withdrawal from acute alcohol intoxication or withdrawal, or from one or more other substances of abuse. Social detoxification provides access into care and treatment of alcohol or substance use disorders through monitored withdrawal, evaluation of present or potential alcohol or substance dependency and other physical ailments, and intervention into the progression of the disease through timely utilization or resources. Length of stay in a social detoxification program varies from three (3) to seven (7) days depending on the severity of the disease and withdrawal symptoms. (1-1-08)T

29. Sliding Fee Scale. A scale used to determine an individual's cost for services based on Federal Poverty Guidelines and found in IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." (1-1-08)T

30. Substance Dependence. Substance dependence is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol or other drugs despite significant related problems. The cluster of symptoms can include: tolerance; withdrawal or use of a substance in larger amounts or over a longer period of time than intended; persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time spent in activities related to obtaining or using substances or to recover from their effects; relinquishing important social, occupational or recreational activities because of substance use; and continuing alcohol or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been cause or exacerbated by such use as defined in the DSM-IV-TR. (1-1-08)T

31. Substance-Related Disorders. Substance-related disorders include disorders related to the taking of alcohol or another drug of abuse, to the side effects of a medication and to toxin exposures. They are divided into two (2) groups: the Substance Use Disorders and the Substance-Induced Disorders as defined in the DSM-IV-TR. (1-1-08)T

32. Substance Use Disorder. Includes Substance Dependence and Substance Abuse, according to the DSM-IV-TR. Substance Use Disorders are one (1) of two (2) subgroups of the broader diagnostic category of Substance-Related Disorders. (1-1-08)T

33. Substantial Material Change in Circumstances. A substantial and material change in circumstances which renders the Department's decision denying alcohol and substance use disorders services arbitrary and capricious. (1-1-08)T

011. -- 099. (RESERVED).

100. ACCESSING ALCOHOL AND SUBSTANCE DISORDERS SERVICES.
Adult and adolescent alcohol and substance disorders services may be accessed by eligible

applicants through an application and request for an intake eligibility screening. (1-1-08)T

101. INTAKE ELIGIBILITY SCREENING AND FULL CLINICAL ASSESSMENT.

01. Intake Eligibility Screening. A screening for eligibility for alcohol and substance use disorders services through the Department is based on meeting priority population and ASAM PPC-2R criteria as incorporated by reference in Section 004 of these rules. If an applicant meets this criteria he may be eligible for alcohol and substance use disorders services through the Department. Applicants not meeting this criteria will be referred to other appropriate community services. All applicants are required to complete an Application for Alcohol and Substance Use Disorders Services either over the telephone or in person at a network treatment provider site. If an applicant refuses to complete the application, the Department reserves the right to discontinue the screening process for eligibility. The intake eligibility screening must be directly related to the applicant's substance dependence or substance-related disorder and level of functioning, and will include: (1-1-08)T

a. Application for Alcohol or Substance Use Disorders Services, pending document approval; (1-1-08)T

b. Notice of Privacy Practice; (1-1-08)T

c. Fee Determination; and (1-1-08)T

d. Authorization for Disclosure. (1-1-08)T

02. Full Clinical Assessment. If the applicant is found eligible for alcohol and substance use disorders services after completion of the intake eligibility screening, the applicant will either be placed on a waiting list to receive a full clinical assessment or will have an appointment made to receive a full clinical assessment with a Department's network treatment provider. (1-1-08)T

102. ELIGIBILITY DETERMINATION.

01. Determination of Eligibility for Alcohol and Substance Use Disorders Services. The total number of adults and adolescents who are eligible for alcohol or substance use disorders services through the Department will be established by the Department, in consultation with the Idaho Interagency Committee on Substance Abuse Prevention and Treatment. The Department may, in consultation with the Idaho Interagency Committee on Substance Abuse Prevention and Treatment, limit or prioritize adult and adolescent alcohol or substance use disorder services, define eligibility criteria, and establish the number of persons eligible based upon such factors as court-ordered services, availability of funding, the degree of financial need, the degree of clinical need, or other factors. (1-1-08)T

02. Eligibility Requirements. To be eligible for alcohol and substance use disorders services through a voluntary application to the Department, the applicant must: (1-1-08)T

a. Be an adult or adolescent with family income at or below one hundred seventy-five per cent (175%) of federal poverty guidelines; (1-1-08)T

b. Be a resident of the state of Idaho; (1-1-08)T

c. Be a member of the priority population; (1-1-08)T

d. Meet diagnostic criteria for substance dependence, or a substance-related disorder as described in the DSM-IV-TR; and (1-1-08)T

e. Meet specifications in each of the ASAM PPC-2R dimensions required for the recommended level of care. (1-1-08)T

02. Admission to Treatment Program Requirements. In order to be admitted into an adult or adolescent alcohol or substance use disorders treatment program, there must be clinical evidence that provides a reasonable expectation that the applicant will benefit from the alcohol or substance use disorder services. (1-1-08)T

03. Ineligible Conditions. An applicant who has epilepsy, mental retardation, dementia, a developmental disability, physical disability, mental illness, or who is aged, is not eligible for alcohol and substance use disorders services, unless, in addition to such condition, they meet primary diagnostic criteria for substance abuse, substance dependence, or a substance related disorder as described in the DSM-IV-TR and the specification in each of the ASAM PPC-2R dimensions required for the recommended level of care. (1-1-08)T

103. NOTICE OF CHANGES IN ELIGIBILITY FOR ALCOHOL AND SUBSTANCE USE DISORDERS SERVICES.
The Department may, upon ten (10) days' written notice, reduce, limit, suspend, or terminate eligibility for alcohol or substance use disorders services. (1-1-08)T

104. NOTICE OF DECISION ON ELIGIBILITY.

01. Notification of Eligibility Determination. Within two (2) business days of a receiving a completed intake eligibility screening and risk assessment for outpatient services, and one (1) business day for social detoxification and residential treatment services; the Department, or its contracted intermediary, will notify the applicant or the applicant's designated representative in writing of its eligibility determination. The written notice will include: (1-1-08)T

a. The applicant's name and identifying information; (1-1-08)T

b. A statement of the decision; (1-1-08)T

c. A concise statement of the reasons for the decision; and (1-1-08)T

d. The process for pursuing an administrative appeal regarding eligibility determinations. (1-1-08)T

02. Right to Accept or Reject Alcohol and Substance Use Disorders Services. If the Department, or its contracted intermediary, determines that an applicant is eligible for alcohol and substance use disorders services through the Department, an individual has the right to accept

or reject alcohol and substance use disorders services offered by the Department, unless imposed by law or court order. (1-1-08)T

03. Reapplication for Alcohol and Substance Use Disorders Services. If the Department determines that an applicant is not eligible for alcohol and substance use disorders services through the Department, the applicant may reapply after six (6) months or at any time upon a showing of a substantial material change in circumstances. Also, if the individual screened is found not to meet admission criteria, but is in need of other types of services, the Department, or its contracted intermediary, will refer the individual to an agency or department which provides the appropriate services needed. (1-1-08)T

106. -- 199. (RESERVED).

200. INDIVIDUALIZED TREATMENT PLAN, SELECTION OF SERVICE PROVIDERS AND AVAILABLE TREATMENT SERVICES.
The Department's contracted treatment provider will prepare for every client an individualized treatment plan that addresses the alcohol or substance disorders health affects on the client's major life areas. The treatment plan will be based on a biopsychosocial assessment of the client's alcohol or substance use disorders treatment needs. (1-1-08)T

01. Individualized Treatment Plan. Overall responsibility for development and implementation of the plan will be assigned to a qualified professional staff member within a Department contracted network treatment provider program. A detailed individualized treatment plan will be developed within fourteen (14) days following the Department's determination that an applicant is eligible for alcohol and substance use disorders services through the Department. The individualized treatment plan will include the following: (1-1-08)T

a. The services clinically necessary to meet the client's alcohol and substance use disorders needs; (1-1-08)T

b. Referrals for needed adjunct services that the alcohol and substance use disorders treatment program does not provide; (1-1-08)T

c. Goals that the client must achieve; (1-1-08)T

d. Specific objectives that relate to the goals, written in measurable terms, with targeted expected achievement dates; (1-1-08)T

e. Frequency of services; (1-1-08)T

f. Specific criteria to be met for discharge from treatment; and (1-1-08)T

g. A specific plan for including the family or significant others. (1-1-08)T

02. Selection of Providers. The client can choose from among the array of substance use disorders treatment providers approved to provide services. The services must be within the recommended level of care according to ASAM PPC-2R and based on needs identified in the biopsychosocial assessment and resultant individualized treatment plan. The client does not have

the option of choosing his treatment provider if he is within the criminal justice system and specific providers have been identified for the client. (1-1-08)T

03. Treatment Services Available. Available alcohol or substance use disorders treatment services, as defined in Section 010 of these rules, include: (1-1-08)T

a. Early intervention; (1-1-08)T

b. Outpatient services; (1-1-08)T

c. Intensive outpatient services; (1-1-08)T

d. Residential social detoxification; (1-1-08)T

e. Medical detoxification; (1-1-08)T

f. Clinically managed low-intensity residential treatment; (1-1-08)T

g. Clinically managed medium intensity residential treatment; and (1-1-08)T

h. Clinically managed high-intensity residential treatment. (1-1-08)T

04. Treatment Services Not Available. Alcohol or substance use disorder treatment services, do not include: (1-1-08)T

a. Experimental or investigational procedures; (1-1-08)T

b. Technologies and related services; (1-1-08)T

c. Electroconvulsive therapy; (1-1-08)T

d. Treatment or services for epilepsy, mental retardation, dementia, a developmental disability, physical disability, aged or the infirm; or (1-1-08)T

e. Any other services which are primarily recreational or diversional in nature. (1-1-08)T

201. -- 299. (RESERVED).

300. CHARGES FOR ALCOHOL AND SUBSTANCE USE DISORDERS SERVICES. Individuals receiving alcohol and substance use disorders services through the Department are responsible for paying for the services provided. Individuals must complete a “Fee Determination Form,” in writing or by telephone, prior to the delivery of alcohol and substance use disorders services. The amount charged for each service will be in accordance with the individual's ability to pay as determined in: IDAPA 16.07.01, “Behavioral Health Sliding Fee Schedules,” Section 500. (1-1-08)T

301. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.33 - ADULT MENTAL HEALTH SERVICES

DOCKET NO. 16-0733-0801 - (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2008.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 39-3133, and 56-1003(3)(c), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than Wednesday, January 16, 2008.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

In accordance with Executive Order 2006-18, the Department created a new Division of Behavioral Health. This new division is responsible for administering mental health services for adults. Currently, there is no chapter pertaining to the oversight of adult mental health services and this new chapter is needed to fill that void.

Currently, there is no formal appeal process in rule for adults seeking mental health services from the Department. This rulemaking provides this appeal process and outlines how to appeal a denial of services decision made by the Department. This new chapter also defines the scope of voluntary adult mental health services and describes the eligibility criteria, application requirements, individualized treatment plan, and selection of providers under these rules.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate as this rulemaking confers a benefit.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this new chapter was developed primarily to establish the benefit of appeal rights for adults receiving mental health services under these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Scott Tiffany, Division of Behavioral Health, at (208) 332-7243.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, January 23, 2008.

DATED this 5th day of November, 2007.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-6558 fax
kovachs@dhw.idaho.gov e-mail

THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

IDAPA 16
TITLE 07
CHAPTER 33

16.07.33 - ADULT MENTAL HEALTH SERVICES

000. LEGAL AUTHORITY.

The Idaho Legislature has delegated to the Department of Health and Welfare, as the state mental health authority, the responsibility to ensure that mental health services are available throughout the state of Idaho to individuals who need such care and who meet certain eligibility criteria under the Regional Mental Health Services Act, Title 39, Chapter 31, Idaho Code. Under Section 39-3133, Idaho Code, the Department is authorized to promulgate rules to carry out the purposes and intent of the Regional Mental Health Services Act. Under Section 56-1003(3)(c), Idaho Code, the Director is authorized to adopt rules to supervise and administer a mental health program.
(1-1-08)T

001. TITLE AND SCOPE.

01. Title. The title of these rules is, IDAPA 16.07.33, "Adult Mental Health Services." (1-1-08)T

02. Scope. (1-1-08)T

a. This chapter defines the scope of voluntary adult mental health services administered under the Department's Division of Behavioral Health, and describes the eligibility criteria, application requirements, individualized treatment plan requirements, and appeal process under these rules. This chapter is not intended to, and does not, establish an entitlement for or to receive adult mental health services, nor is it intended to be applicable to individuals ordered by the court to receive mental health services. (1-1-08)T

b. The priority population for this chapter is adult individuals, voluntarily seeking mental health services, who are residents of Idaho and have a primary diagnosis of serious and persistent mental illness. However, under certain circumstances, in accordance with the waiver provision in Section 400 of these rules, adult mental health services may be available to those who do not have a primary diagnosis of serious and persistent mental illness. (1-1-08)T

002. WRITTEN INTERPRETATIONS.
There are no written interpretations for these rules. (1-1-08)T

003. ADMINISTRATIVE APPEALS.

01. Appeal of Denial Based on Eligibility Criteria. Administrative appeals from a denial of mental health services based on the eligibility criteria under Section 102 of these rules are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (1-1-08)T

02. Appeal of Decision Based on Clinical Judgment. All decisions involving clinical judgment, including the category of services, the particular provider of services, or the duration of services, are reserved to Department, and are not subject to appeal, administratively or otherwise, in accordance with *Maresh v. State,* 132 Idaho 221, 970 P.2d 14 (Idaho 1999). (1-1-08)T

004. INCORPORATION BY REFERENCE.
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) Washington, DC, American Psychiatric Association, 2000, is hereby incorporated by reference under this chapter of rules. Copies of the manual are available from the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (1-1-08)T

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEB SITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the State of Idaho. (1-1-08)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (1-1-08)T

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (1-1-08)T

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (1-1-08)T

05. Internet Web Site. The Department's internet web site is found at: http://www.healthandwelfare.idaho.gov. (1-1-08)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." (1-1-08)T

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (1-1-08)T

007. -- 008. (RESERVED).

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History and Background Check. All current Department employees, applicants, transfers, reinstated former employees, student interns, contract employees, volunteers, and others assigned to programs that involve direct contact with children or vulnerable adults as described in Section 39-5302, Idaho Code, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-08)T

02. Availability to Work or Provide Service. Certain individuals are allowed to provide services after the self-declaration is completed as provided in Section 56-1004A, Idaho Code, except when they have disclosed a designated crime listed in IDAPA 16.05.06, "Criminal History and Background Checks." The criminal history check requirements applicable to each provider type are found in the rules that state the qualifications or certification of those providers. (1-1-08)T

010. DEFINITIONS.
For the purposes of these rules, the following terms are used as defined below: (1-1-08)T

01. Adult. An individual eighteen (18) years of age or older. (1-1-08)T

02. Adult Mental Health Services. Adult mental health services include psychiatric clinical services, case management, individual therapy, group therapy, psychosocial rehabilitation (PSR), assertive community treatment (ACT), patient assistance program (PAP), benefit assistance, co-occurring disorders treatment, and pharmacological education. Mental health services do not include educational or vocational services related to traditional academic subjects or vocational training, experimental procedures, habilitation, or any other services which are primarily recreational or diversional in nature. (1-1-08)T

03. Applicant. An adult individual who is seeking mental health services through the Department who has completed, or had completed on his behalf, an application for mental health services. (1-1-08)T

04. Client. A person receiving mental health services through the Department. The term "client" is synonymous with the following terms: patient, participant, resident, consumer, or recipient of treatment or services. (1-1-08)T

05. Clinical Judgment. Refers to observations and perceptions based upon education, experience, and clinical assessment. This may include psychometric, behavioral, and clinical interview assessments that are structured, integrated, and then used to reach decisions, individually or collectively, about an individual's functional, mental, and behavioral attributes and mental health service needs. (1-1-08)T

06. Clinical Necessity. Adult mental health services are deemed clinically necessary when the Department, in the exercise of clinical judgment, recommends services to an applicant for the purpose of evaluating, diagnosing, or treating a mental illness and that are: (1-1-08)T

a. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for treating the applicant's mental illness; and (1-1-08)T

b. Not primarily for the convenience of the applicant or service provider, not more costly than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the applicant's mental illness. (1-1-08)T

07. Clinical Team. A proposed client's clinical team may include: qualified clinicians, behavioral health professionals, professionals other than behavioral health professionals, behavioral health technicians, and any other individual deemed appropriate and necessary to ensure that the treatment is comprehensive and meets the needs of the proposed client. (1-1-08)T

08. Department. The Idaho Department of Health and Welfare or its designee. The Department is designated as the State Mental Health Authority under Section 39-3124, Idaho Code. (1-1-08)T

09. Emergency. An emergency exists if an adult individual is gravely disabled due to mental illness or there is a substantial risk that physical harm will be inflicted by the proposed client: (1-1-08)T

a. Upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself; or (1-1-08)T

b. Upon another person, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm. (1-1-08)T

10. Federal Poverty Guidelines. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found at: http://aspe.hhs.gov/poverty/. (1-1-08)T

11. Functional Impairment. Difficulties that substantially impair or limit role functioning with an individual's basic daily living skills, or functioning in social, family, vocational, or educational contexts including psychiatric, health, medical, financial, and community or legal area, or both. (1-1-08)T

12. Gravely Disabled. An adult who, as a result of mental illness, is in danger of serious physical harm due to the person's inability to provide for any of his basic needs for nourishment, essential medical care, shelter, or safety. (1-1-08)T

13. Individualized Treatment Plan. A written action plan based on an intake eligibility assessment, that identifies the applicant's clinical needs, the strategy for providing services to meet those needs, treatment goals and objectives, and the criteria for terminating the specified interventions. (1-1-08)T

14. Intake Eligibility Assessment. The collection of data, analysis, and review that the Department uses to screen and determine whether an applicant is eligible for mental health services available through the Department. (1-1-08)T

15. Serious Mental Illness (SMI). Means any of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-IV-TR): (1-1-08)T

a. Schizophrenia; (1-1-08)T

b. Paranoia and other psychotic disorders; (1-1-08)T

c. Bipolar disorders (mixed, manic and depressive); (1-1-08)T

d. Major depressive disorders (single episode or recurrent); (1-1-08)T

e. Schizoaffective disorders; and (1-1-08)T

f. Obsessive-compulsive disorders. (1-1-08)T

16. Serious and Persistent Mental Illness (SPMI). A primary diagnosis under DSM-IV-TR of Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified (NOS) for a maximum of one hundred twenty (120) days without a conclusive

diagnosis. The psychiatric disorder must be of sufficient severity to cause a substantial disturbance in role performance or coping skills in at least two (2) of the following functional areas in the last six (6) months: (1-1-08)T

a. Vocational or educational, or both. (1-1-08)T

b. Financial. (1-1-08)T

c. Social relationships or support, or both. (1-1-08)T

d. Family. (1-1-08)T

e. Basic daily living skills. (1-1-08)T

f. Housing. (1-1-08)T

g. Community or legal, or both. (1-1-08)T

h. Health or medical, or both. (1-1-08)T

17. Sliding Fee Scale. A scale used to determine an individual's cost for services based on Federal Poverty Guidelines and found in IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." (1-1-08)T

18. Substantial Material Change in Circumstances. A substantial and material change in circumstances which renders the Department's decision denying mental health services arbitrary and capricious. (1-1-08)T

011. -- 099. (RESERVED).

100. ACCESSING ADULT MENTAL HEALTH SERVICES.
Adult mental health services may be accessed by eligible applicants through an application and request for initial intake eligibility assessment. (1-1-08)T

101. ELIGIBILITY SCREENING AND INTAKE ELIGIBILITY ASSESSMENT.

01. Eligibility Screening. A screening for eligibility for adult mental health services through the Department is based on the eligibility criteria under Section 102 of these rules. If an applicant meets the eligibility criteria, he may be eligible for adult mental health services through the Department. If an applicant does not meet the eligibility criteria, he may be referred to other appropriate services. All applicants are required to complete an Application for Mental Health Services. If an applicant refuses to complete the Application for Mental Health Services, the Department reserves the right to discontinue the screening process for eligibility. (1-1-08)T

02. Intake Eligibility Assessment. A qualified clinician will complete an intake eligibility assessment on the Department-approved form. The intake eligibility assessment and supplemental psychiatric, psychological, or other specialty evaluations and tests must be dated, signed, and retained in the applicant's medical record. The intake eligibility assessment must be

directly related to the applicant's mental illness and level of functioning, and will include: (1-1-08)T

a. Application for Mental Health Services, pending document approval; (1-1-08)T

b. Notice of Privacy Practice (HW 0320); (1-1-08)T

c. Mental Health Client Profile; (1-1-08)T

d. Fee Determination Form (HW 0735); (1-1-08)T

e. Adult Health History Form (HW 0713); (1-1-08)T

f. Family Health History Form (HW 0715); and (1-1-08)T

g. Authorization for Disclosure. (1-1-08)T

102. ELIGIBILITY DETERMINATION.

01. The Department Determines Eligibility for Mental Health Services. The total number of adults who are eligible for mental health services through the Department will be established by the Department. The Department may, in its sole discretion, limit or prioritize mental health services, define eligibility criteria, or establish the number of persons eligible based upon such factors as court-ordered services, availability of funding, the degree of financial need, the degree of clinical need, or other factors. (1-1-08)T

02. Eligibility Requirements. To be eligible for mental health services through a voluntary application to the Department, the applicant must: (1-1-08)T

a. Be an adult; and (1-1-08)T

b. Be a resident of the state of Idaho; and (1-1-08)T

c. Have a primary diagnosis of SPMI; or (1-1-08)T

d. Be determined eligible under the waiver provisions in Section 400 of these rules. (1-1-08)T

03. Ineligible Conditions. An applicant who has epilepsy, mental retardation, dementia, a developmental disability, physical disability, or who is aged or impaired by chronic alcoholism or drug abuse, is not eligible for mental health services, unless, in addition to such condition, he has a primary diagnosis of SPMI or is determined eligible under the waiver provisions in Section 400 of these rules. (1-1-08)T

103. NOTICE OF CHANGES IN ELIGIBILITY FOR MENTAL HEALTH SERVICES. The Department may, upon ten (10) days' written notice, reduce, limit, suspend, or terminate eligibility for mental health services. (1-1-08)T

104. EMERGENCY SERVICES.

01. Determination of the Need for Emergency Services. At an applicant's first visit, and prior to making a final determination of eligibility, the Department will determine whether an applicant needs services to alleviate an emergency as defined under Section 010 of these rules. (1-1-08)T

02. Identification of the Emergency Services Needed. If emergency services are clinically necessary, as determined by the Department, the Department will identify the emergency services that are consistent with the applicant's needs and the preliminary findings of the intake eligibility assessment or subsequent assessments and: (1-1-08)T

a. Arrange for the provision of the emergency services; and (1-1-08)T

b. Document in the applicant's record the emergency services that are to be provided to the applicant. (1-1-08)T

03. Immediate Intervention. If the Department determines that an emergency exists necessitating immediate intervention, emergency or crisis services will be arranged immediately. (1-1-08)T

105. NOTICE OF DECISION ON ELIGIBILITY.

01. Notification of Eligibility Determination. Within ten (10) business days of a receiving a completed intake eligibility assessment, the Department will notify the applicant or the applicant's designated representative in writing of its eligibility determination. The written notice will include: (1-1-08)T

a. The applicant's name and identifying information; (1-1-08)T

b. A statement of the decision; (1-1-08)T

c. A concise statement of the reasons for the decision; and (1-1-08)T

d. The process for pursuing an administrative appeal regarding eligibility determinations. (1-1-08)T

02. Right to Accept or Reject Mental Health Services. If the Department determines that an applicant is eligible for mental health services through the Department, an individual has the right to accept or reject mental health services offered by the Department, unless imposed by law or court order. (1-1-08)T

03. Reapplication for Mental Health Services. If the Department determines that an applicant is not eligible for mental health services through the Department, the applicant may reapply after six (6) months or at any time upon a showing of a substantial material change in circumstances. (1-1-08)T

106. -- 199. (RESERVED).

200. INDIVIDUALIZED TREATMENT PLAN AND SELECTION OF SERVICE PROVIDERS.
The Department will prepare an individualized treatment plan for every client that addresses the mental health effects on the major life areas and is based on an assessment of the client's mental health needs. (1-1-08)T

01. Individualized Treatment Plan. Overall responsibility for development and implementation of the plan will be assigned to a qualified professional staff member. A detailed individualized treatment plan will be developed within thirty (30) days following the Department's determination that an applicant is eligible for mental health services through the Department. The individualized treatment plan will include the following: (1-1-08)T

a. The services clinically necessary to meet the client's mental health needs; (1-1-08)T

b. Referrals for needed services not provided under these rules; (1-1-08)T

c. Goals that the client is to achieve; (1-1-08)T

d. Specific objectives that relate to the goals, written in measurable terms, with expected achievement dates; (1-1-08)T

e. Frequency of services; (1-1-08)T

f. Specific criteria to be met for discharge from treatment; and (1-1-08)T

g. A specific plan for including the family or significant others. (1-1-08)T

02. Selection of Providers. Within five (5) days of completing the individualized treatment plan, the clinical team will identify and select service providers most appropriate to meet the client's mental health needs. The case manager will promptly contact the identified providers to determine their ability to serve the client. (1-1-08)T

201. -- 299. (RESERVED).

300. CHARGES FOR MENTAL HEALTH SERVICES.
Individuals receiving adult mental health services through the Department are responsible for paying for the services provided. Individuals must complete a "Fee Determination Form" prior to the delivery of adult mental health services. The amount charged for each service will be in accordance with the individual's ability to pay as determined under Sections 300 and 400 of IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." (1-1-08)T

301. -- 399. (RESERVED).

400. WAIVERS.

01. Waiver of Certain Eligibility Criteria. Subject to funding, availability of adult

mental health services or adult mental health providers, and the number of clients receiving adult mental health services through the Department, the Department may consider waiving, in its sole discretion, the eligibility requirement that applicants have a primary diagnosis of SPMI. (1-1-08)T

02. A Waiver Decision Does Not Establish a Precedent. The Department's decision to grant a waiver, or not, to an applicant neither establishes a precedent nor is it applicable to any other applicant for a waiver. (1-1-08)T

03. Waiver Decisions Are Not Subject to Review or Appeal. The Department's actions and decisions pertaining to waivers are not subject to review or appeal, administratively or otherwise, in accordance with *Maresh v. State*, 132 Idaho 221, 970 P.2d 14 (Idaho 1999). Waivers are not admissible in administrative hearings or proceedings under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (1-1-08)T

401. -- 999. (RESERVED).

IDAPA 27 - IDAHO STATE BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0601

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is June 16, 2006.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 16, 2006.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The proposed rulemaking provides a mechanism for the initiation of a Remote Dispensing Pilot Program that will allow for the dispensing of prescriptions through remote dispensing machines.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(2)(a) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

The temporary rulemaking is necessary to protect the public health, safety, and welfare, and to confer a benefit by providing pharmaceutical care through the use of telecommunications and remote dispensing machines to patients at a distance from the pharmacy and pharmacist providing the pharmaceutical care.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because of the experimental nature of the Remote Dispensing Pilot Program.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact R. K. "Mick" Markuson, Director, (208) 334-2356.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2006.

DATED this 16th day of June 2006.

R. K. "Mick" Markuson, Director
Idaho State Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720, Boise ID 83720-0067
Phone: (208) 334-2356; Fax: (208) 334-3536

THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

010. DEFINITIONS.

01. **Board**. Idaho Board of Pharmacy. (6-16-06)T

0~~1~~2. **Pharmacist Extern**. Any person enrolled in an approved college of pharmacy who has not received his first professional degree in pharmacy, and who is obtaining experience under the supervision of a pharmacist preceptor. (6-30-95)

0~~2~~3. **Pharmacist Intern**. Any person who has successfully completed a course of study at an accredited college or school of pharmacy and received the first professional degree in pharmacy, and who is obtaining practical experience under the supervision of a pharmacist preceptor. (6-30-95)

0~~3~~4. **Preceptor**. A licensed pharmacist in good standing engaged in the practice of pharmacy at a registered training site and directly responsible in supervising the training of a pharmacist extern or intern. The preceptor shall be responsible for: (6-30-95)

a. Personally providing the extern or intern with training experience which in his judgment will increase the extern or intern's proficiency; and (6-30-95)

b. Reporting to the Board upon request, the progress of any pharmacy extern or intern under his supervision; and (6-30-95)

c. Certifying the extern or intern's experience affidavits when the extern or intern

leaves his supervision. (6-30-95)

0~~4~~5. Ratios. A ratio of one (1) pharmacist preceptor to one (1) extern or intern will be required for dispensing functions. (6-30-95)

(BREAK IN CONTINUITY OF SUBSECTIONS)

265. REMOTE DISPENSING PILOT PROJECT.
The Board, through its Executive Director, may authorize specific pharmacies and the pharmacists practicing therein to participate in a Remote Dispensing Pilot Program. The following rules shall apply to pharmacies so authorized by the Board for conducting pharmacy through a Remote Dispensing Program. The purpose of the Remote Dispensing Pilot Program is to allow the provision of pharmaceutical care through the use of telecommunications and Remote Dispensing Machines (RDM) to patients at a distance from the pharmacy and pharmacist providing the pharmaceutical care. During the pilot project phase of the Remote Dispensing Pilot Program, designation to participate in the Remote Dispensing Pilot Program shall be at the discretion of the Board and the Executive Director. (6-16-06)T

26~~5~~6. ~~290.~~ (RESERVED).

267. REMOTE PHARMACY REGISTRATION - OPERATING MEMORANDUM.

01. Registration. During the pilot project phase of the Remote Dispensing Pilot Project, each Remote Pharmacy shall be registered with the Board as a Pilot Remote Pharmacy. Pilot Remote Pharmacies will only be approved for operating in medical care facilities operating in areas otherwise unable to obtain pharmaceutical care on a timely basis. RDMs must be used only in settings with an established program of pharmaceutical care that ensures prescription orders are reviewed by a pharmacist before release to the patient. The Responsible Pharmacy must establish the policies and procedures necessary to fulfill the requirements of all applicable state and federal laws, rules, and regulations. (6-16-06)T

02. Operating Memorandum. Prior to issuance of a registration for a Pilot Remote Pharmacy, the Responsible Pharmacy, acting through its Pharmacist in Charge, and the Board, acting through its Executive Director, shall enter into an operating memorandum which shall contain: (6-16-06)T

a. The operating protocols applicable to the Pilot Remote Pharmacy and which shall include written policies and procedures that: (6-16-06)T

i. Ensure safety, accuracy, security, and patient confidentiality; (6-16-06)T

ii. Define access to the RDM and to medications contained within or associated with the RDM, including but not limited to policies that assign, discontinue, or change access to the RDM and medications; and (6-16-06)T

iii. Ensure that access to the medications complies with state and federal laws and regulations. (6-16-06)T

b. A complete description of the RDM including the operating specifications therefore. (6-16-06)T

c. An accurate scale drawing of the facility where the Automated Pharmacy System, including its RDM, will be located showing the layout of the location of the RDM, the facilities for the operating pharmacy technician operating the system, the location of a patient counseling area, all access points to the system and the RDM. (6-16-06)T

d. A description of the training required for personnel who will access the Automated Pharmacy System (including the RDM) to ensure the competence and ability of all personnel who operate any component of the Automated Pharmacy System and a requirement that adequate documentation of training and continuing education be kept both in the Responsible Pharmacy and at the Pilot Remote Pharmacy, readily available for inspection by the Board. (6-16-06)T

e. A description of the procedures for ensuring that the RDM is in good working order and accurately dispenses the correct strength, dosage form, and quantity of the drug prescribed while maintaining appropriate record-keeping and security safeguards. (6-16-06)T

f. An ongoing quality assurance program that monitors performance of the Automated Pharmacy System, including the RDM, and the personnel who access it. (6-16-06)T

g. Such other terms and conditions of operations as the Executive Director deems are reasonably necessary to ensure the health, safety, and welfare of the public with respect to the operations of the Pilot Remote Pharmacy. (6-16-06)T

03. Pilot Remote Pharmacy Operations. The Operating Memorandum shall govern (in conjunction with all applicable laws, rules, and regulations) the operations of the Pilot Remote Pharmacy with respect to all aspects of the practice of pharmacy at the Pilot Remote Pharmacy. The Operating Memorandum may identify specific rules of the Board which are not applicable to the operation of the Pilot Remote Pharmacy or for which particular applications are modified due to the specific nature of the operations at the Pilot Remote Pharmacy, provided however, the Operating Agreement may not waive or modify application of Federal laws or regulations, or state statutes governing the practice of pharmacy. (6-16-06)T

04. Dispute Resolution. In the event of a dispute between the Pharmacist in Charge and the Executive Director with respect to specific terms or conditions of the Operating Memorandum, either may petition the Board for a determination, which determination by the Board shall be final. The Operating Memorandum may be amended by agreement between the Responsible Pharmacist and the Executive Director. Any such amendment shall be in writing and shall be appended to the original Operating Memorandum. In addition, the Operating Agreement may be amended by order of the Board upon the petition of either the Responsible Pharmacist or the Executive Director to the Board, or upon the Board's own motion. Any such Board order shall be appended to the original Operating Memorandum. (6-16-06)T

268. PHARMACIST IN CHARGE.

01. Responsibilities. The Pharmacist in Charge shall be responsible for all aspects of the operation of the Pilot Remote Pharmacy including safety, accuracy, security, and patient confidentiality. (6-16-06)T

02. Product Supply. The Pharmacist in Charge shall ensure that the RDM is stocked accurately and in accordance with the established, written policies and procedures. A pharmacist must check the accuracy of the product supplied for stocking the machine. (6-16-06)T

269. DRUG DELIVERY AND CONTROL.

01. Licensed Pharmacist Present. At all times the Automated Pharmacy System is being operated, there shall be a pharmacist licensed in the state of Idaho, or a technician registered in the state of Idaho, present at the Pilot Remote Pharmacy and attending to such operations. (6-16-06)T

02. Communication. At all times the Automated Pharmacy System is being operated, there shall be a pharmacist licensed in the state of Idaho available at the Responsible Pharmacy for immediate communication through a two-way audio and video hookup between the Responsible Pharmacy and the Pilot Remote Pharmacy. (6-16-06)T

03. Electronic Recording. All events involving the contents of the RDM must be recorded electronically. Records must be maintained by the Responsible Pharmacy for a minimum of three (3) years and must be readily available to the Board. Such records are in addition to any records required under other statutes, regulations, or rules, and shall be available for inspection by the Board in the same fashion as other required pharmacy records, and shall include: (6-16-06)T

a. Identity of RDM accessed; (6-16-06)T

b. Identification of the individual accessing the RDM; (6-16-06)T

c. Type of transaction; (6-16-06)T

d. Date and time of transaction; (6-16-06)T

e. Name, strength, dosage form, and quantity of the drug accessed; (6-16-06)T

f. Name of the patient for whom the drug was ordered; (6-16-06)T

g. Name of the prescribing practitioner; and (6-16-06)T

h. Such additional information as the Pharmacist in Charge may deem necessary. (6-16-06)T

04. Access to RDM. Only an Idaho licensed pharmacist may have access to the RDM. (6-16-06)T

05. Stocking Medications. Only an Idaho licensed pharmacist may stock medications in the RDM. (6-16-06)T

06. Packaging and Labeling. All containers of medications stored in the RDM shall be packaged and labeled in accordance with state and federal laws, rules, and regulations. (6-16-06)T

07. Handling Controlled Substances. All aspects of handling controlled substances shall meet the requirements of all state and federal laws, rules, and regulations. (6-16-06)T

08. Counseling. Oral counseling shall be provided by a pharmacist licensed in Idaho at the time of dispensing by a two-way audio and video hookup between the Responsible Pharmacy and the Pilot Remote Pharmacy. (6-16-06)T

09. Wasted, Discarded, or Unused Medications. The Automated Pharmacy Systems shall provide a mechanism for securing and accounting for wasted, discarded, or unused medications in accordance with existing state and federal laws, rules, and regulations. (6-16-06)T

10. RDM Identification. The RDM must be clearly marked with the name, address, and phone number of the Responsible Pharmacy and Pharmacist in Charge. (6-16-06)T

270. -- 290. (RESERVED).